PPACA ENROLLMENT AND THE INSURANCE INDUSTRY

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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PPACA ENROLLMENT AND THE INSURANCE INDUSTRY

WEDNESDAY, MAY 7, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:18 a.m., in room 2123, Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, Burgess, Blackburn, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Barton, Upton (ex officio), DeGette, Braley, Lujan, Schakowsky, Castor, Tonko, Yarmuth, Green, Dingell, and Waxman (ex officio).

Staff Present: Gary Andres, Staff Director; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, O&I; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, O&I; Alexa Marrero, Deputy Staff Director; Christopher Pope, Fellow, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Tom Wilbur, Digital Media Advisor; Jessica Wilkerson, Legislative Clerk; Jean Woodrow, Director, Information Technology; Phil Barnett, Minority Staff Director; Stacia Cardille, Minority Chief Counsel; Brian Cohen, Minority Staff Director, Oversight & Investigations, Senior Policy Advisor; Hannah Green, Minority Staff Assistant; Karen Nelson, Minority Deputy Committee Staff Director For Health; Stephen Salsbury, Minority Investigator; and Matt Siegler, Minority Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I now convene this hearing to examine the implementation of the Affordable Care Act and enrollment of the State and Federal exchanges here in the Oversight and Investigations Committee for the Committee on Energy and Commerce.

This subcommittee has a long history of trying to get straight answers from the administration on the status of the Affordable Care Act. Two weeks before the launch of HealthCare.Gov, the administration official responsible for the implementation of the ACA exchanges told this committee that the Web site would be ready, consumers would be able to go online, shop for a select plan and then enroll in coverage.

When the Federal exchange opened on October 1, consumers instead found a crashing Web site. The administration's excuse for why the Web site didn't work: Volume. Through this committee's investigation, we learned that the administration spent over $.5 billion on a Web site that they had been warned for several months would not be ready and would not work. Facts that administration officials did not disclose when questioned by this committee during oversight hearings through 2013.

Just after the failed launch, we asked the administration on October 8 to provide enrollment data for the first week of the HealthCare.Gov debacle. The administration ignored us. Why? It wasn't because the data didn't exist; it was because the news wasn't good. When Secretary Sebelius testified before the full Energy and Commerce Committee on October 30 of last year, was asked about enrollment, she stated that she could not provide any data because the administration did not "have any reliable data around enrollment."

The very next day, it was reported that there were only six successful enrollments on October 1. We tried again during a hearing in January before this subcommittee when we asked the head of the office running the exchanges if the administration collected any data on who has paid their health coverage. This administration official told us that they did not collect this information "but we will be," as soon as it was finished building the Web site.

While the administration refused to provide straightforward answers to our questions on enrollment, it continues to tout enrollment figures that included individuals who had merely selected a plan online. When pressed by reporters for information on the number of enrollees who had paid their premiums, a White House spokesman said that questions about payment "can best be directed to those private insurance companies that are collecting those payments."

After months of an administration that refused to be transparent about enrollment, that's what we did; we did exactly what the administration suggested we do. On March 13, we sent a request to each insurance company in the Federal marketplace and asked them to submit basic information: Who selected a plan and who paid for it?

The data submitted by the insurers paints an uneven picture about the status of enrollment and payment through April 15. As of that date, just two-thirds of enrollees through the Federally-facilitated marketplace paid their first month premium. Some States are doing better than others.

My home State of Pennsylvania, for example, has an 81 percent payment rate. Texas, on the other hand, is much lower at 42 percent. We recognize that many individuals still have time to pay their first month's premium, which is why we have asked the insurers to update this information on May 20. As with any criticism or questions of the Affordable Care Act, the administration predictably protested and attempted to misrepresent the purpose of our inquiry.

Let's be clear about why we had to engage in this exercise in the first place. The administration would not be transparent about enrollment and provide the underlying data. For the witnesses today,

we ask you to be patient with our questions about enrollment and implementation. After months of promises about the status of HealthCare.Gov from HHS officials, we have learned to be skeptical about blanket statements that everything is well.

One purpose of today's hearing is to examine enrollment because it is a key factor in measuring whether these exchanges are viable. We have a number of other questions for the witnesses today about the status of implementation. The ACA is more than a payment rate. We need to know if Americans can expect the premium reductions they were promised, and we need to know if they can keep the plan they liked. We need to know if they can keep their doctor.

We cannot understand the status of the law in its implementation without hearing from you, the insurance companies, whose plans make up these exchanges. Under the President's health care law, these companies will receive taxpayer dollars in the form of premium subsidies and cost sharing. We expect the witnesses today to provide the committee with facts and information about the first year of coverage under the Affordable Care Act.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

This subcommittee has had a long history trying to get straight answers from this Administration on the status of the Affordable Care Act. Two weeks before the launch of HealthCare.gov, the administration official responsible for the implementation of the ACA exchanges told this Committee that the Web site would be ready. Consumers would be able to go online, shop for and select a plan, and enroll in coverage.

When the federal exchange opened on October 1, consumers instead found a crashing Web site. The administration's excuse for why the Web site didn't work? Volume.

Through this Committee's investigation, we learned that the administration spent over half a billion dollars on a Web site that they had been warned for months would not be ready and would not work—facts that administration officials did not disclose when questioned by this Committee during oversight hearings throughout 2013.

Just after the failed launch, we asked the administration on October 8 to provide enrollment data for the first week of the HealthCare.gov debacle. The administration ignored us. Why? It wasn't because the data didn't exist. It was because the news wasn't good. When Secretary Sebelius testified before the full Energy and Commerce Committee on October 30 and was asked about enrollment, she stated that could not provide any data because the administration did not "have any reliable data around enrollment."

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While the administration refused to provide straightforward answers to our questions on enrollment, it continued to tout enrollment figures that included individuals who had merely selected a plan online. When pressed by reporters for information on the number of enrollees who had paid their premiums, a White House spokesman said that questions about payment "can best be directed to those private insurance companies that are collecting those payments."

After months of an administration that refused to be transparent about enrollment, that's what we did. On March 13, we sent a request to each insurance company in the federal marketplace and asked them to submit basic information: who selected a plan, and who paid for it. The data submitted by the insurers paints an uneven picture about the status of enrollment and payment through April 15. As of that date, just two-thirds of enrollees through the federally-facilitated marketplace paid their first month premium. Some states are doing better than others. My home state of Pennsylvania has an 81 percent payment rate. Texas, on the other

hand, is much lower, at 42 percent. We recognize that many individuals still have time to pay their first month's premium, which is why we have asked the insurers to update this information on May 20.

As with any criticism or questions of the Affordable Care Act, the administration predictably howled in protest and attempted to misrepresent the purpose of our inquiry. Let's be clear about why we had to engage in this exercise in the first place: the administration would not be transparent about enrollment and provide the underlying data. For the witnesses today, we ask you to be patient with our questions about enrollment and implementation. After months of promises about the status of HealthCare.gov from HHS officials, we have learned to be skeptical about blanket statements that "all is well."

One purpose of today's hearing is to examine enrollment, because it is a key factor in measuring whether these exchanges are viable. We have a number of other questions for the witnesses today about the status of implementation. The ACA is more than a payment rate. We need to know if Americans can expect the premium reductions they were promised. We need to know if they can keep the plan they liked. We need to know if they can keep their doctor. We cannot understand the status of the law and its implementation without hearing from the insurance companies whose plans make up these exchanges. Under the President's health care law, these companies will receive taxpayer dollars in the form of premium subsidies and cost-sharing. We expect the witnesses today to provide the Committee with facts and information about the first year of coverage under the Affordable Care Act.

Mr. MURPHY. Thank you to the witnesses for being here today, and I now would like to recognize the ranking member, Ms. DeGette, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman. I just want to take a few minutes, since the chairman has walked through the greatest hits of the problems they have had with the ACA, of where we stand now and where we stand after the first enrollment period has just closed. So as we continue to get information about how the exchanges in the Affordable Care Act and the enrollment are performing, let's review what we already know.

The first thing is, despite the disastrous beginning of the Federal exchange, good news: The Web site was fixed. More than 8 million people signed up for insurance through the exchanges created through the Affordable Care Act which is more than 1 million more than were originally projected before the disastrous unveiling.

Now, of those 8 million people, 3 million of them waited until the last month of enrollment, and so their premiums are not due until April 30, or in some cases, later than April 30. Even so, my colleagues, in their quest for knowledge on the other side of the aisle, sent out a questionnaire to insurers that manipulated the payment deadlines to skew the understanding of how new insurance coverage is performing.

How does that happen? Because they cut off the responses April 15, at least 2 weeks before many of the premiums of these 3 million people were even due for payment. What this does is it skews the amount of people who were enrolled. Then, of course, they issued a press release posthaste.

Now, for years, my friends on the other side of the aisle have made a series of claims that really are unsubstantiated. First, they claimed that the bill contained death panels, then they claimed that the bill would eliminate private insurance within 3 years, then they claimed that the law would destroy millions of jobs. When the

Web site was broken, they insisted the law would never meet enrollment goals.

Now, Mr. Chairman, today we finally have a chance to see in a snapshot what's happening with the Affordable Care Act, and the facts reveal that every single one of those claims were wrong. As of today, as I said, more than 8 million people enrolled in private plans through Federal and State marketplaces. Millions more have enrolled through Medicaid and in off-exchange plans.

Gallup just released a new poll finding that in the last 6 months, the percentage of adults without insurance has dropped about 20 percent, and what that means is there are more than 11 million Americans with insurance today than there were 6 months ago. Premiums are below the levels predicted by the Congressional Budget Office, and the agency has once again reiterated that the Affordable Care Act has slowed inflation and saved billions of dollars and will even reduce deficits. So by any rational, reasonable measure, we can call this law success, and that success will make a real difference in people's lives. That's what's important here.

Yesterday, researchers from the Harvard School of Public Health released a comprehensive study on the impacts of health insurance coverage. They were looking at mortality rates before and after the passage of RomneyCare, the landmark Massachusetts health insurance expansion that served as a model for the Affordable Care Act. They found that the mortality rate in Massachusetts fell by about 3 percent in the 4 years after passage of the State's health insurance law.

Mr. Chairman, I would like to ask unanimous consent to put a copy of that study into the record.

Mr. MURPHY. Without objection.

Ms. DEGETTE. Thank you.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. So if we can achieve that same level of success nationwide with the Affordable Care Act, and there's no reason why we shouldn't be able to do so, that could result in 17,000 fewer deaths per year. That, Mr. Chairman, in a nutshell, is what the Affordable Care Act means for Americans.

Now, what I wish we could do in this subcommittee, and I've said this both publicly and privately many, many times, is sit down with the ACA, figure out what the flaws are and figure out how we can work in a bipartisan way to fix it. And that's what I think we should do. Instead, what we get is this misleading analysis last week which said that only 67 percent of enrollees had paid for the coverage they enrolled in on the exchanges.

And my chairman, Mr. Upton, said the administration's recent declarations of success may be unfounded. But again, I will say, the report was misleading because almost half of the enrollees in the health care exchanges, 40 percent of them, did not even have to make their initial premium payment until April 31. I'm glad we've got the insurers here today to clear up this record. I'm glad we have everybody here to see exactly what we're talking about here.

So my suggestion is, let's look at the successes, let's look where we need to make improvements, and let's work together to do just that. Thank you.

Mr. MURPHY. Gentlelady's time has expired.

Now recognize the chairman of the full committee, Mr. Upton for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. With a friendly pat on the back, I'll just say April 31 has yet to come. "30 days has September, April, June and November."

Thank you, Mr. Chairman. I thank the witnesses for being here today as well, for sure. At this subcommittee, our investigations are about getting the facts. A quest for transparency, the self-proclaimed most transparent administration in history has repeatedly dodged our simple questions about the health care law and refused even a semblance of transparency about how its signature legislative achievement is or is not working.

We wanted the basic data from the administration on enrollment 1 week after the launch of HealthCare.Gov, and the administration has rejected our request for more information each and every time. Members of the press have asked. The administration suggested the only way to get the facts was directly asking the insurance providers themselves. So we took their advice and we did just that, but the administration cried foul again.

We began asking about HealthCare.Gov months before October 1 of last year. Repeatedly, we are told things were on track and working the way it was supposed to. We learned that this was not the case and the administration officials did everything in their power, it seems, to hide the chaos behind the scenes.

The American public does deserve better. They deserve better than an administration that promised them $2,500 in savings on health care premiums only to see the cost rise sharply for many. They deserve better than an administration that repeated promises officials knew that would be impossible to keep, promises that Americans could keep their doctors and keep their health care plans, also.

Like it or not, millions of Americans have found themselves with the unwelcome reality of cancellations and lost access to their trusted doctor. And one Democratic colleague from Massachusetts said just 2 weeks ago, the worst is yet to come.

Today we are going to hear firsthand from insurance providers about how implementation is working from their perspective. While the administration has declared this conversation over, the fact is that serious questions remain unanswered, and it is our responsibility to continue seeking the facts.

How many people have completed the enrollment process? Are the risks presented by these pools sustainable? How much more will premiums rise this next year? Is the back end of the Web site on track to be working by the next enrollment period? Are there any other delays or changes ahead that will disrupt the ability of families and businesses to plan for their health care coverage and needs? Will more health care plans be canceled in the coming years?

So what's wrong with seeking that information? Nothing that I know of. We released basic data points on enrollment as of April 15, and we'll do so again on the data that we collect through May

20. The facts are the facts, and while the administration and its allies furiously try to muddy reality, the public deserves transparency.

And while the administration toasts to the law's success with its Hollywood allies, declaring this conversation over, we will continue our pursuit for facts for the American people so that we can finally have a full, accurate picture of this health care law, and I yield the balance of my time to Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

At this subcommittee, our investigations are about getting the facts—a quest for transparency. The self-proclaimed "most transparent administration in history" has repeatedly dodged our simple questions about the health care law and refused even a semblance of transparency about how its signature legislative achievement is—or is not—working.

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Today we will hear first hand from the insurance providers about how implementation is working from their perspective. While the administration has declared this conversation over, the fact is that serious questions remain unanswered. And it is our responsibility to continue seeking the facts. How many people have completed the enrollment process? Are the risks presented by these pools sustainable? How much more will premiums rise next year? Is the backend of the Web site on track to be working by the next enrollment period? Are there any other delays or changes ahead that will disrupt the ability of families and businesses to plan for their health care coverage and needs? Will more health care plans be cancelled in the coming years?

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Mr. BURGESS. I thank the chairman for yielding.

I thank our witnesses for being here today. I know it's not always easy or pleasant to come before this subcommittee. I, like the chairman, wish that the administration had been a little bit more forthcoming about information which would have obviated your need to be here today, but I do appreciate the fact that you responded to our requests and that you have provided the data.

The fact remains the administration has withheld facts or changed facts during the rollout of this law and that the Federal agencies responsible for the implementation currently excel only in

opacity. So you are here today to provide that transparency that the American people were promised earlier in this administration, and I thank you for being here.

I have particular concern over one aspect, and I will delve into it a little bit more during the questioning today, but that is the issue on the grace period, the 90-day period of time that is granted to people who are receiving the tax credits, the advance tax credits for the offset of the cost of their insurance. If they don't pay their premium in spite of the tax credit, they are given a grace period of 90 days.

My understanding is that the companies will be responsible for the first 30 days; beyond that, it will be the doctor or the hospital, the provider who submits the bill who may be on the hook for that. And I am very interested to know what you have in development to keep practices, to keep providers apprised of the fact that a patient's claim may be in a pending status when that claim is submitted.

I know from running a doctor's office, you always call and verify benefits, but now we have a new realm that we've entered into: Not only would you identify that someone has been enrolled, but that they've paid and that they're current on their payments so that the provider in question would not be at risk. So we will get into a little bit more on that in the question-and-answer period.

I thank the chairman for the time and yield back.

Mr. MURPHY. Gentleman's time has expired.

I now recognize the ranking member of the full committee, Mr. Waxman, for 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

Last week the Republican whip, Representative Kevin McCarthy, wrote an op-ed opposing the Affordable Care Act. He wrote, "President Obama needs to learn a simple lesson: Saying something doesn't make it true." Well, psychologists call this projection, a defense mechanism that involves ascribing your own behavior to others.

In one phrase, Representative McCarthy summed up 5 years of Republican opposition to the Affordable Care Act. Over and over, Republican leaders have fabricated criticisms of the Affordable Care Act and none of them have been true. Republican leaders said that the ACA would create death panels; well, there are none in the law. Republican leaders said that the law was unconstitutional; the Supreme Court held exactly the opposite. Republican leaders said that the ACA would increase the deficit; well, the nonpartisan Congressional Budget Office found that the law will reduce deficits by over $1 trillion. Republican leaders said that the law would cause health care costs to skyrocket; in fact, in the 3 years after passage of the ACA, health care spending growth was at its lowest rate in 50 years.

Republican leaders said that the law would cause massive job losses; in reality, there have been 48 consecutive months of job creation since the ACA was passed with more than 9.2 million jobs

created. Republican leaders said there would be a huge loss of coverage under the law, but every independent analysis shows that the number of Americans with health insurance is growing and the number of uninsured dropping rapidly. Republicans said enrollment would fall far short of CBO estimates because few Americans would sign up; at 8 million and growing, enrollment has exceeded everyone's expectations.

Mr. Chairman, I just summarized 5 years of relentless Republican opposition to the Affordable Care Act. It's a sad and, I believe, reprehensible record. The Republican Party is trying to scare families from getting the health insurance they need. We saw the same pattern just last week when this committee released another report claiming imminent failure. This time, the report said that one-third of enrollees had not paid for coverage. There was just one problem: The data was incomplete, out of date, and manipulated. Due to the late surge in enrollment, premiums were not even due for over 3 million Americans.

The testimony we're going to hear today from the insurers contradicts the Republican findings. That testimony says that 80 to 90 percent of enrollees have paid their premiums. Mr. Chairman, it was a mistake to release those inaccurate and misleading findings, and it's not the first time this has happened.

This morning, I released a memo describing the Republican record of distortion, exaggeration, and misdirection. It's a sad record, and I'd like to make it part of this hearing record. The simple fact is, despite 5 years of ceaseless opposition, the Affordable Care Act is working. Over 8 million Americans have signed up for private health care coverage on the State and Federal exchanges. Millions more have signed up for Medicaid. Premiums are well below CBO expectations. No American ever has to fear being discriminated against or denied coverage based on a preexisting condition.

No amount of blatant falsehoods and cynical partisanship can obscure the facts. The Affordable Care Act is an enormous step forward in the health of our Nation. And I yield back the balance of my time, and I appreciate this opportunity to set the record straight.

Mr. MURPHY. Thank you. The gentleman yields back.

We'll now move forward here with our witnesses. Just one moment, please. We're moving quicker and that's good. I just wasn't quite ready.

So I'd like to introduce the panel for today's hearing. We have Mr. Mark Pratt, who is a senior vice president of State Affairs for America's Health Insurance Plans; Mr. Frank Coyne is the Vice President of Operations and Chief Transformation Officer of Blue Cross and Blue Shield Association; Mr. Paul Wingle is the Executive Director of Individual Businesses and Public Exchange Operations and Strategy for Aetna; Mr. Brian Evanko is the President of Individual Segment for Cigna Health and Life Insurance Company; Mr. J. Darren Rodgers is the Senior Vice President and Chief Marketing Officer at the Health Care Services Corporations; and Mr. Dennis Matheis is the President of Central Region and Exchange Strategy at WellPoint, Inc.

I will now swear in the witnesses. You are aware that this committee is holding an investigative hearing and when doing so, we have the practice of taking testimony under oath. Do any of you have any objections to testifying under oath? All the witnesses have indicated no.

The chair, then, advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

Mr. Wingle is saying you would like to be advised by counsel. Well, if you are sitting behind him, that's fine.

Anybody else? You have counsel behind you. You are certainly are welcome at some point to ask clarification from them, that's fine.

In any case, would you all please rise and raise your right hand, and I'll swear you in.

[Witnesses sworn.]

Mr. MURPHY. Thank you. You may be seated. All the witnesses have taken that oath, and you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. We'll have you now each give a 5-minute opening statement. Please stick to the 5 minutes. You'll see a red light go on when you're at the end of your time.

Mr. Pratt, you may begin.

STATEMENTS OF MARK PRATT, SENIOR VICE PRESIDENT OF STATE AFFAIRS, AMERICAS HEALTH INSURANCE PLANS; FRANK COYNE, VICE PRESIDENT OF OPERATIONS, CHIEF TRANSFORMATION OFFICER, BLUE CROSS AND BLUE SHIELD ASSOCIATION; PAUL WINGLE, EXECUTIVE DIRECTOR OF INDIVIDUAL BUSINESS AND PUBLIC EXCHANGE OPERATIONS AND STRATEGY, AETNA; BRIAN EVANKO, PRESIDENT, INDIVIDUAL SEGMENT, CIGNA; J. DARREN RODGERS, SENIOR VICE PRESIDENT AND CHIEF MARKETING OFFICER, HEALTH CARE SERVICE CORPORATION; AND DENNIS MATHEIS, PRESIDENT OF CENTRAL REGION AND EXCHANGE STRATEGY, WELLPOINT, INC.

STATEMENT OF MARK PRATT

Mr. PRATT. Chairman Murphy, Ranking Member DeGette and members of the subcommittee, I am Mark Pratt, Senior Vice President of State Affairs in America's Health Insurance Plans. I lead AHIP's legislative and regulatory activities in the States, including implementation of the Affordable Care Act and our work with the National Association of Insurance Commissioners. We appreciate this opportunity to testify on enrollment in the new health insurance exchanges and implementation of the ACA.

Our written testimony focuses on two broad areas: One, our members' experience in the ACA's initial open enrollment period for 2014; and two, our members' priorities for improving access to high-quality affordable health coverage in 2015 and beyond. Since the enactment of the ACA, our members have been working the implement the law's many requirements with a strong focus on delivering high value coverage options for consumers. Helping them ob-

tain the secure, affordable coverage they need has been our central goal throughout the implementation process.

While working on operational issues related to ACA implementation and providing recommendations to policymakers, our members have focused on several major goals. Among them: Minimizing disruptions for consumers, businesses and stakeholders; ensuring the workability of the exchanges and allowing State flexibility; maximizing choice and competition; and addressing specific ACA provisions to make health coverage more affordable.

On numerous issues, our members have provided technical assistance and expertise to assist Federal agencies in resolving the operational challenges that surrounded the launch of the new exchanges in the HealthCare.Gov Web site. They have devoted significant resources to performing manual processes and workarounds that were necessitated by the problems following the October 1 launch. Despite the challenges our members encountered, we are proud that they ultimately were successful in offering a broad range of high-valued coverage options to consumers who are enrolled in exchanges in 2014.

HHS has reported that approximately 8 million individuals signed up for exchange plans during the initial open enrollment period for 2014. While uncertainty remains with respect to how many people have paid their first month's premium, health insurers have been doing everything possible to encourage exchange enrollees to pay their premiums.

In the coming weeks, we anticipate that there will be greater clarity on the question of how many exchange enrollees have paid their premiums. A number of individual plans have publicly announced their preliminary data, and we anticipate that more announcements will be forthcoming; however, it may be a period of time before system-wide numbers on premiums payments are available. Our members will continue their ongoing outreach to encourage exchange enrollees to pay their premiums.

Looking forward, we continue to believe that affordability must be the central priority as we focus on further expanding access to high quality, affordable health insurance coverage in 2015 and beyond. One critically important step that Congress can take to make coverage more affordable is to delay the ACA health insurance tax and eventually repeal it.

We are deeply concerned that this tax is undermining efforts to control costs and provide affordable coverage options. We strongly support bipartisan legislation to fully repeal the tax introduced by Representatives Boustany and Matheson and cosponsored by 230 House members. We also support as a short-term solution separate bipartisan legislation that proposes a 2-year delay on the tax.

On another front and in closing, we have worked closely with our members to provide comments to Federal agencies on dozens of proposed rules and other regulatory documents. We consistently have emphasized the importance of creating a regulatory environment that promotes a wide range of affordable coverage options. Thank you again for this opportunity to testify. I look forward to your questions.

Mr. MURPHY. Thank you, Mr. Pratt. I thank you for yielding back.

[The prepared statement of Mr. Pratt follows:]

PPACA Enrollment and the Insurance Industry

by

Mark Pratt
Senior Vice President, State Affairs
America's Health Insurance Plans

for the
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations

May 7, 2014

I. Introduction

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am Mark Pratt, Senior Vice President for State Affairs at America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. I lead AHIP's legislative and regulatory activities in the states, including implementation of the Affordable Care Act and our work with the National Association of Insurance Commissioners. My role includes daily involvement in issues relating to the state-based Exchanges and state Medicaid programs, working with leading stakeholder organizations and government officials from across the country. I previously was employed as head of government affairs for Anthem Blue Cross and Blue Shield in Virginia, as a principal for a Washington DC-based public affairs consulting firm, and as Executive Director of the Virginia Association of Health Plans.

AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to testify on enrollment in the new health insurance Exchanges and other issues relating to implementation of the Affordable Care Act (ACA). Throughout the ACA implementation process, our members have worked closely with federal and state officials to address a broad range of regulatory and operational issues to help consumers get the coverage

they need. Health insurers remain strongly committed to continuing to serve consumers and participate in the new marketplaces established by the law.

Our testimony focuses on two broad areas: (1) our members' experience in the ACA's initial open enrollment period for 2014, including issues surrounding the payment of premiums by consumers who have signed up for coverage; and (2) our members' priorities for improving access to high quality, affordable health insurance coverage in 2015 and beyond.

II. Our Members' Experience in the Open Enrollment Period for 2014

Since the enactment of the ACA, our members have been working to implement the law's many requirements with a strong focus on delivering high-value coverage options in the most affordable and least disruptive manner possible. To give consumers greater peace of mind about their health care coverage, health plans have implemented some reforms ahead of schedule and, as we discuss below, provided consumers greater flexibility with payment deadlines to help avoid potential gaps in coverage. Helping consumers obtain the secure, affordable coverage they need has been our central goal throughout the implementation process.

As part of this process, health plans have worked diligently to comply with the thousands of pages of regulations, directives, information requests, guidance, and other regulatory documents that the Department of Health and Human Services (HHS) and other federal agencies have issued to implement various statutory provisions of the ACA. While working on operational issues

related to ACA implementation and providing recommendations to policymakers, our members consistently have focused on several major goals:

- Minimizing disruptions for consumers, businesses, states, and stakeholders;

- Ensuring the workability of the operational architecture of Exchanges and allowing state flexibility;

- Maximizing coordination to prevent redundant state and federal regulations and data collections and focusing on ways to reduce administrative cost burdens;

- Maximizing choice and competition; and

- Addressing specific ACA provisions to make health coverage more affordable for consumers and purchasers.

On a broad range of issues, our members have provided technical assistance and expertise to assist federal agencies in resolving the operational challenges that surrounded the launch of the new Exchanges and the healthcare.gov website. They also have devoted significant resources to performing manual processes and work-arounds that were necessitated by the problems that surfaced in the days and weeks following the October 1 launch. Under ever-changing deadlines and operational guidance, they processed enrollment files and payments in short timeframes. They also supported consumers through the open enrollment process by providing online

educational resources, increasing customer service call center hours and support (in response to unprecedented numbers of phone calls from consumers who needed help navigating the enrollment process), and partnering with community groups, health care stakeholders, and faith-based organizations to reach under-served communities. Despite the challenges our members encountered, we are proud that they ultimately were successful in offering a broad range of high-value coverage options to consumers who are enrolled in Exchange plans for 2014.

HHS has reported that approximately 8 million individuals signed up for Exchange plans during the initial open enrollment period for 2014. While there is some uncertainty with respect to how many people have paid their first month's premium, health insurers have been doing everything possible to encourage Exchange enrollees to pay their premiums. We appreciate the committee's interest in learning more about this issue, particularly in light of the information you released last week based on data provided by insurers participating in the federally-facilitated Exchange.

One reason there is uncertainty about the number of Exchange enrollees who have paid their premiums is that some insurers – to provide peace of mind for consumers and to protect them from potential gaps in coverage – have voluntarily decided to provide flexibility in the deadline by which Exchange enrollees must pay their first month's premium. This flexibility is allowed under an interim final rule published by HHS on December 17, 2013.

Other factors also contribute to the uncertainty about how many Exchange enrollees have paid their premiums:

- **Changing enrollment:** In early February, CMS implemented the functionality for Exchange enrollees to voluntarily terminate their plan or to report a "life event" (i.e., a change in circumstance, such as a new baby or job, which allows a special enrollment period). While this functionality serves a valid purpose, it creates challenges in calculating accurate enrollment data and payment rates.

- **Duplicate enrollments:** Because of the challenges that surfaced with the launch of the Exchanges in October 2013, some consumers were advised to create a new account and enroll again. As a result, insurers have many duplicate enrollments in their system for which they never received any payment. In cases where an insurer has a new enrollment for a consumer who previously enrolled, they are not expecting that original policy to be effectuated – even though that data is still reported.

In the coming weeks, as we move further past the conclusion of the open enrollment period for 2014, we anticipate that there will be greater clarity on the question of how many Exchange enrollees have paid their premiums. A number of individual plans have publicly announced their data, and we anticipate that more announcements will be forthcoming. However, given the significant variation in enrollment that occurs in the individual marketplace, it may be a matter of months before system-wide numbers on premium payments are available. Our members will continue their ongoing outreach and communication efforts to encourage Exchange enrollees to pay their premiums.

III. Our Members' Priorities for 2015 and Beyond

Looking forward, we continue to believe that affordability must be the central priority – for Congress, the Administration, the states, and stakeholders – as we focus on further expanding access to high quality, affordable health insurance coverage in 2015 and beyond.

Repeal of ACA Health Insurance Tax

One critically important step that Congress can take to make coverage more affordable is to delay and eventually repeal the ACA's health insurance tax. The health insurance tax began in 2014 and will exceed $100 billion over the next ten years. The tax is set at $8 billion in 2014, and increases by over 40 percent to $11.3 billion in 2015, and to $14.3 billion by 2018. In subsequent years, the tax will increase annually based on premium growth.

We are deeply concerned that implementation of the new health insurance tax is undermining efforts to control costs and provide affordable coverage options. An Oliver Wyman study[1], commissioned by AHIP, has concluded that the health insurance tax alone will increase the cost of family coverage in the individual market by an average of $5,080 over the ten-year period of 2014-2023. This study also estimated that the health insurance tax will increase the cost of family coverage in the small group market by an average of $6,830 over the same ten-year period. Additionally, a state-by-state analysis[2] by Oliver Wyman has provided per-person and cumulative estimates of the impact this tax will have on individual market consumers,

[1] Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. October 2011.
[2] Carlson, Chris. "Annual Tax on Insurers Allocated by State." Oliver Wyman. November 2012.

employers, and Medicare Advantage enrollees in all 50 states, as well as the impact on state Medicaid managed care programs.

The findings of the Oliver Wyman studies reinforce our deep concern that the new health insurance tax is having a significant negative impact on the affordability of coverage. To address this concern, we strongly support bipartisan legislation (H.R. 763) to fully repeal the health insurance tax, introduced by Reps. Charles Boustany (R-LA) and Jim Matheson (D-UT). To date, 230 House members have cosponsored this bill, including 30 members of the House Energy and Commerce Committee. We also support – as a short-term solution – separate bipartisan legislation (H.R. 3367), introduced by Reps. Charles Boustany (R-LA) and Ami Bera (D-CA), that proposes a two-year delay in the ACA health insurance tax.

Regulatory Changes to Make Coverage More Affordable

Throughout the ACA implementation process, we have worked closely with our members to provide comments to federal agencies on dozens of proposed rules and other regulatory documents. We consistently have emphasized the importance of creating a regulatory environment that promotes a wide range of affordable coverage options. We have cautioned that regulatory policies that increase the cost of coverage or restrict consumer choice may encourage individuals to forego purchasing coverage until after they are sick or injured. This is particularly true for young and healthy individuals who are extremely sensitive to the cost of coverage and who are a key demographic of the reformed marketplace. We remain concerned that adverse selection and unnecessarily high costs will occur in the absence of broad participation in the new Exchanges. These serious concerns – along with the experience of our members at the

operational level – have shaped our comments and recommendations to the agencies on a broad range of regulatory issues.

Long-Term Policy Options for Improving Quality and Affordability

Additional steps to make coverage more affordable are outlined in a document we released in December 2013 – "A Roadmap to High Quality Affordable Health Care for All Americans."[3] This report discusses the health care cost challenges facing our nation, the innovative programs health plans are implementing to promote value and reduce costs, and policy options for promoting a sustainable, high quality health care system.

The policy recommendations in our report focus on improving quality of care and enhancing value for consumers and patients by building upon existing innovations in the private sector and public-private collaborations. We recommend action in the following areas:

- **Advancing a state-based gain sharing program to encourage innovation and cost savings.** The program we propose would provide shared savings incentives to reward states that are able to reduce future increases in health care costs through innovative programs and collaboration with stakeholders.

- **Accelerating health system and delivery reforms to transform the health care system and promote value.** This includes improving Medicare/Medicaid integration for "dual eligibles," implementing financial incentives for providers that improve patient safety, expanding the use of patient-centered medical homes, encouraging broader adoption of

[3] "A Roadmap to High Quality Affordable Health Care for All Americans," AHIP, November 2013.

"bundled payments" to promote greater value and quality of care, encouraging accountable care models that promote effective collaborations between insurers and providers for improving quality and lowering cost, streamlining high-value quality measures, and removing barriers to allow stakeholders to advance global payment models as a way to realign financial incentives toward high quality, lower cost care.

- **Addressing underlying health care cost drivers and paying for care that is proven to work.** This includes tackling barriers to transparency, incorporating the findings of comparative effectiveness research into coverage and reimbursement decisions by both public and private payers, reducing the exclusivity period for biologics and biosimilars, prohibiting anticompetitive patent settlements between drug companies, and adopting quality measures that evaluate generic prescribing practices.

- **Strengthening the health care infrastructure.** This includes reducing administrative overhead and costs through administrative simplification, and improving quality through medical liability reforms.

- **Stamping out fraud and abuse.** This includes fighting fraud in public programs with "best practices" commonly used in the private sector, employing the next generation of information technology tools, and ensuring that collaborations between health plans and public partners accelerate the fight against fraud based on a flexible partnership.

IV. Conclusion

Thank you again for this opportunity to testify. Our members remain strongly committed to working with Congress, the Administration, the states, and other stakeholders to expand access to high quality, affordable coverage options.

Mr. MURPHY. Now, I recognize Mr. Coyne for his 5 minutes. Thank you.

STATEMENT OF FRANK COYNE

Mr. COYNE. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for the invitation to testify here today. I am Frank Coyne, Vice President in the Office of the President for the Blue Cross and Blue Shield Association, which represents the 37 independent community-based Blue Cross and Blue Shield companies that collectively provide health coverage for 100 million Americans.

Blue Cross and Blue Shield companies offer health care coverage in every ZIP Code in the country and have long been committed to offering consumers across the country a wide variety of insurance options. My remarks today focus on the Blue's participation in the Multi-State Plan Program administered by the Office of Personnel Management and enrollment in Blue Cross and Blue Shield MSP plans.

The Affordable Care Act authorizes OPM to contract with at least two entities, at least one of which must be a not-for-profit to offer products on the State and Federal marketplaces. Under this Multi-State Plan Program, OPM certifies health plans in conjunction with States for placement on the exchanges.

For 2014, OPM certified Blue Cross and Blue Shield companies to offer Multi-State Plan products in 30 States and the District of Columbia. Collectively, Blue Cross and Blue Shield companies offered more than 150 Multi-State Plan products. OPM has developed a standard contract for OPM issuers that meets its requirements. The association is party to that contract with OPM and are Blue licensee plans have agreements with us to fulfill many aspects of that contract, such as customer enrollment, benefits and claims administration and customer service, among other activities.

In addition, the contract contains a requirement to report enrollment information to OPM. In order to fulfill this requirement, we ask Blue plans to report information on their Multi-State Plan enrollments to us, and we convey enrollment information to OPM. As of April 1, 2014, a total of 283,783 individuals have selected an MSP plan.

I appreciate the opportunity to discuss Blue participation and enrollment in the MSP plan, and I look forward to your questions.

Mr. MURPHY. Thank you, Mr. Coyne.

[The prepared statement of Mr. Coyne follows:]

BlueCross BlueShield Association

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Testimony

Before the

Subcommittee on Oversight and Investigations
Energy and Commerce Committee
U.S. House of Representatives

on

PPACA Enrollment and the Insurance Industry

Presented by:

Frank E. Coyne
Vice President, Office of the President

May 7, 2014

INTRODUCTION

Thank you Chairman Murphy, Ranking Member DeGette, Chairman Upton, Ranking Member Waxman and members of the Oversight and Investigations Subcommittee for this opportunity to testify today on enrollment in the new Exchange marketplaces.

I am Frank Coyne, Vice President, Office of the President of the Blue Cross and Blue Shield Association ("BCBSA") – a national federation representing the 37 independent, community-based, and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide health care coverage for 100 million members, one in three Americans, in every U.S. ZIP code. Blue Cross and Blue Shield Plans offer a variety of insurance products to all segments of the population, including large employer groups, small business, individuals and government programs.

I am responsible for oversight of BCBSA's participation in the Multi-State Plan (MSP) Program administered by the Office of Personnel Management (OPM).

OVERVIEW OF TESTIMONY

My testimony today focuses on:

1) BCBSA participation in OPM's Multi-State Plan program; and
2) Enrollment figures to-date in Blue Cross and Blue Shield MSP plans.

OPM MULTI-STATE PROGRAM STRUCTURE AND TERMS

The Affordable Care Act (ACA) authorizes OPM to contract with at least two entities, at least one of which must be a not-for-profit, to offer products on the state and Federal Exchange marketplaces phased-in over a 4-year timeframe. Under this program, called the Multi-State Plan Program, OPM certifies health plans in conjunction with States, for placement on the Exchanges.

For the individual market, the MSP plans are to be phased in, with products available in 60 percent of states by 2014, 70 percent by 2015, 85 percent by 2016, and 100 percent by 2017. For 2014, MSP individual market products are required in 31 states.

The MSP Program is regulated under provisions of the ACA and OPM's MSP Program regulations. The MSP Program operates on a "level playing field" with plans adhering to the same federal and state requirements as all other qualified health plans (QHPs). For example, our MSP plans adhere to the same local essential health benefit (EHB) benchmarks as QHPs. Issuers may apply to be certified to offer MSP products, and the application process is similar to the Federally-Facilitated Marketplace (FFM) application process. To be eligible, an entity must be an health insurance issuer, or a group of issuers with common ownership or a common service mark. The Association fits the latter case.

In addition, OPM has developed a standard contract for the Issuers that meet its requirements. In our case, the Association is party to the contract, and our Blue licensee Plans have agreements with us to fulfill many aspects of the contract, such as customer enrollment, benefits and claims administration, and customer service, among other activities.

The contract contains a requirement to report enrollment information to OPM. In order to fulfill this requirement, we ask our Plans to report on their MSP enrollment to us, and we convey enrollment information to OPM.

BCBSA PARTICIPATION IN THE MULTI-STATE PLAN PROGRAM

Blue Cross and Blue Shield Plans traditionally offer consumers across the country a wide variety of coverage options. For 2014, OPM certified Blue Cross and Blue Shield Plans to offer MSP products in 30 states and the District of Columbia. The total number of MSP plans offered exceeds 150.

Our participation in the MSP Program is part of our longstanding commitment to providing consumers with a variety of health plan choices so that they have access to affordable plans that best meet their healthcare needs.

ENROLLMENT IN THE MULTI-STATE PROGRAM

Consumers' interest in the Multi-State Plan Program has been significant. As of April 1, 2014, a

total of 283,783 individuals have selected an MSP plan.

CONCLUSION

Blue Cross Blue Shield is committed to working with OPM and Members of the Subcommittee to ensure consumers continue to have access to broad range of affordable plans. I appreciate the opportunity to discuss Blue participation and enrollment in the MSP Program, and I look forward to your questions.

Mr. MURPHY. Now, Mr. Wingle, you're recognized for 5 minutes.

STATEMENT OF PAUL WINGLE

Mr. WINGLE. Good morning, Chairman Murphy, Ranking Member DeGette and distinguished members of the subcommittee. My name is Paul Wingle, and I am executive director of Individual Business and Public Exchange Operations and Strategy at Aetna. Thank you for inviting us to today's hearing. I have a brief opening statement and will then be happy to answer any questions you may have.

Aetna is currently participating in the individual market on the exchanges in 17 States. Over the course of approximately the last 2 months, Aetna has worked with the subcommittee to provide requested data and information related to enrollment in plans offered through federally-facilitated marketplaces.

As of the third week of April, Aetna had over 600,000 members who had enrolled, and roughly 500,000 members who had paid. For those who are reached their payment due date, the payment rate, though dynamic, has been in the low- to mid-80 percent range. As outlined in our prior submissions to the subcommittee, these are dynamic figures and do not reflect final enrollment numbers, as some enrollees have not yet reached their payment due dates.

An example would be a member with a June 1 policy effective date who has not yet paid but whose initial payment is not yet due. We are happy to continue to work with the subcommittee to provide updated information and data and note that, as the subcommittee has recognized, this might include material, nonpublic, confidential, and proprietary information.

Thank you again for the opportunity to be here today, and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Wingle follows:]

TESTIMONY OF PAUL WINGLE

EXECUTIVE DIRECTOR, INDIVIDUAL BUSINESS AND PUBLIC EXCHANGE OPERATIONS AND STRATEGY

AETNA, INC.

BEFORE THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND COMMERCE, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING ON "PPACA ENROLLMENT AND THE INSURANCE INDUSTRY"

MAY 7, 2014

Good morning Chairman Murphy, Ranking Member DeGette, and distinguished members of the Subcommittee. My name is Paul Wingle, and I am the Executive Director of Individual Business and Public Exchange Operations and Strategy at Aetna. Thank you for inviting us to today's hearing. I have a brief opening statement and will then be happy to answer any questions you may have.

Aetna is currently participating in the individual market on the exchanges in 17 states. Over the course of approximately the last two months, Aetna has worked with the Subcommittee to provide requested data and information related to enrollment in plans offered through Federally-Facilitated Marketplaces ("FFM"). As of the third week of April, Aetna had over 600,000 members who had enrolled, and roughly 500,000 members who had paid. For those who had reached their payment due date, the payment rate, though dynamic, has been in the low- to mid-80 percent range.

As outlined in our prior submissions to the Subcommittee, these are dynamic figures and do not reflect final enrollment numbers, as some enrollees have not yet reached their payment

due dates (for example, a member with a June 1 policy effective date, who has not yet paid, but whose initial payment is not yet due). We are happy to continue to work with the Subcommittee to provide updated information and data, and note that, as the Subcommittee has recognized, this might include material non-public, confidential, and proprietary information.

Thank you again for the opportunity to be here today, and I would be happy to answer any questions you may have.

Mr. MURPHY. Thank you, Mr. Wingle, he yields back.
And now, Mr. Evanko, you're recognized for 5 minutes.

STATEMENT OF BRIAN EVANKO

Mr. EVANKO. Chairman Murphy, Ranking Member DeGette, members of the subcommittee, good morning and thank you for the opportunity to testify at this hearing on PPACA enrollment and the insurance industry. I'm Brian Evanko, and I currently serve as president of the U.S. Individual Segment at Cigna Corporation. I oversee the operation tasked with developing, promoting and maintaining the Cigna products that are offered in the individual health market, including those products that are offered on the exchanges set up pursuant to the patient protection and Affordable Care Act, or ACA.

Cigna is a global health services company dedicated to helping people improve their health, wellbeing, and sense of security. Through its subsidiaries, Cigna offers an integrated suite of health services, such as medical, dental, behavioral health, pharmacy and vision care benefits, along with other related products including group disability, life, and accident coverage.

We employ more than 26,000 people and have sales capability in 30 countries and jurisdictions. We manage more than 80 million customer relationships throughout the world. Despite our large footprint, 80 percent of Cigna's overall health care business consists of administrative services. This means that we help employers to administer their policies. We also administer claims processes which are not risk-based like traditional insurance. Many of the employers that we assist are self-insuring and the claim payments come out of the employer's own funds.

Cigna's traditional insurance business is concentrated in the large group market. We have a very limited presence in the individual market, including on the ACA exchanges. The individual market currently constitutes approximately 3 percent of Cigna's total revenue. We currently offer health insurance products on the exchanges in five States, four of which—Arizona, Florida, Tennessee, and Texas—are Federally-facilitated marketplaces. The only state-run exchange in which Cigna is participating is in Colorado.

We have entered the exchanges on a focus basis in 2014 to gather deeper learning about consumer behaviors in the individual market, to understand the operational implications of how the exchanges function, and as a potential longer-term source of growth for Cigna. For 2014, we did not expect the exchanges to have a significant financial impact on our company. The health insurance marketplace is evolving rapidly, and Cigna, like other health insurance companies, is constantly challenged to maintain affordability, accessibility, and consumer choice in its product offerings.

Cigna has worked collaboratively with our clients and customers, health care professionals, state, and Federal regulators as well as other stakeholders to maintain our heritage of providing high-quality health insurance products and services while adapting to the ACA and other statutory and regulatory changes.

We believe that health care is a shared responsibility of the individual, the private sector, the medical community and the govern-

ment. Accordingly, we look forward to how we can all work together to improve the health and wellness of and the quality of care for all Americans. I'd welcome any questions that you may have.

[The prepared statement of Mr. Evanko follows:]

Testimony of Brian Evanko
President, U.S. Individual Segment
Cigna Corporation

Hearing before the House Energy & Commerce Committee
Subcommittee on Oversight and Investigations
"PPACA Enrollment and the Insurance Industry"
May 7, 2014

Chairman Murphy, Ranking Member DeGette, members of the Subcommittee, good morning and thank you for inviting me to testify at this hearing on "PPACA Enrollment and the Insurance Industry."

I am Brian Evanko, and I currently serve as President of the U.S. Individual Segment at Cigna Corporation ("Cigna"). I oversee the operation tasked with developing, promoting, and maintaining the Cigna products offered in the individual health insurance market, including those products offered on the exchanges set up pursuant to the Patient Protection and Affordable Care Act or "ACA."

Cigna is a global health service company dedicated to helping people improve their health, well-being, and sense of security. Through its subsidiaries, Cigna offers an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, and vision care benefits, along with other related products including group disability, life, and accident coverage. We employ more than 26,000 people and have sales capability in 30 countries and jurisdictions. We manage more than 80 million customer relationships throughout the world.

Despite our large footprint, 80 percent of Cigna's overall health care business consists of administrative services. This means we help employers administer their policies. We also administer claims processes, which are not risk-based like traditional insurance. Many of the employers we assist are self-insuring and the claim payments come out of the employers' funds.

Cigna's traditional insurance business is concentrated in the large group market. We have a very limited presence in the individual market, including on the ACA exchanges. The individual market constitutes approximately three percent of Cigna's total revenue. Currently, we offer health insurance products on the exchanges in five states, four of which—Arizona, Florida, Tennessee, and Texas—are part of the Federally-Facilitated Marketplace. The only state-run exchange in which Cigna is participating is located in Colorado. We have entered the exchanges on a focused basis in 2014 to gather deeper learning about consumer behaviors in the individual market, the operational implications of how the exchanges function, and as a potential longer term source of growth for Cigna. For 2014, we did not expect the exchanges to have a significant financial impact on our company.

The health insurance marketplace is evolving rapidly, and Cigna, like other health insurance companies, is constantly challenged to maintain affordability, accessibility, and consumer choice in its product offerings. Cigna has worked

collaboratively with our clients and customers, health care professionals, state and federal regulators, as well as other stakeholders to maintain our heritage of providing high quality health insurance products and services while adapting to the ACA and other statutory and regulatory changes. We believe health care is a shared responsibility of the individual, the private sector, the medical community, and the government. Accordingly, we look forward to how we can all work together to improve the health and wellness of—and quality of care for—all Americans.

I welcome any questions you may have.

Mr. MURPHY. Mr. Evanko yields back, and now we go to Mr. Rodgers to be recognized for 5 minutes.

STATEMENT OF J. DARREN RODGERS

Mr. RODGERS. Good morning, Chairman Murphy and members of the subcommittee. I'm Darren Rodgers——

Mr. MURPHY. Bring the mic as close to you as possible because we can't hear up here. Speak right into it.

Mr. RODGERS. Good morning again, everyone. I'm Darren Rodgers. I'm Senior Vice President and Chief Marketing Officer at Health Care Service Corporation or HCSC. HCSC is a mutual legal-reserve company which does business as Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma and Texas. HCSC is the largest customer-owned nonprofit health insurance company in the Nation. We're headquartered in Chicago, Illinois, with a workforce of nearly 20,000 employees serving nearly 14 million members throughout our five State Blue Cross and Blue Shield plans.

For over 80 years, HCSC has been committed to expanding access to cost-effective health care to as many people as possible in every part of each of our five States. Whether through employer-sponsored insurance, government programs or individual products, HCSC is committed to its purpose and to offering our customers a wide range of cost-effective and sustainable product choices to meet their health and wellness needs.

As we transition to a new health care marketplace, HCSC remains committed to its individual and small employer markets and continuing to offering accessible products, particularly to those individuals who do not have access to employer-sponsored coverage.

We're proud of what our brand stands for: Security and peace of mind, and our commitment to our communities in which we operate, as well as our large and geographically-diverse network of health care providers in our operating States. This allows us to offer a variety of affordable product choices in every county of every State in which we operate.

To support our individual and small-employer market, HCSC participated in the health insurance exchanges. We offered a similar portfolio of products both on and off exchange with a variety of deductibles, copays, coverages and other options with the goal of meeting our members' diverse health care needs.

At the current time, enrollment and payment information can only be presented as of each day when the numbers are counted. As such, there are natural lags between the effective date of coverage and the date on which the members' coverage payment may be due. For instance, applicants with policies with an effective date of May 1 still have time remaining in their payment deadline. In addition, adjustments and reconciliations to this data are ongoing. The data HCSC is providing represents our good-faith estimate based on our records to date.

With these caveats, HCSC received between October 1, 2013, and April 15, 2014, approximately 830,000 applications across our five States, comprised of approximately 600,000 on-exchange and 230,000 off-exchange applications. We estimate that these 830,000 applications represent coverage for just over 1.2 million applicants.

In the written copy of my opening statement, we provided a snapshot of our current first-month payment rates. As you can see, January through April looked fairly consistent and range from 83 to 93 percent. The payment rates for May are currently less because payments are still coming in and being posted.

HCSC is and always has been committed to improving access to quality of care for all Americans. I thank you on behalf of HCSC for the opportunity to be a part of this important discussion.

Mr. MURPHY. I thank the gentleman.

[The prepared statement of Mr. Rodgers follows:]

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Oklahoma · Texas

Statement of J. Darren Rodgers, Senior Vice President & Chief Marketing Officer
Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma and Texas
Hearing "*PPACA Enrollment and the Insurance Industry*"
United States House of Representatives, Committee on Energy & Commerce
Subcommittee on Oversight and Investigations
10:15 a.m. Wednesday, May 7, 2014
2125 Rayburn House Office Building

Introduction

Good morning, Chairman Murphy and Members of the Subcommittee. I am Darren Rodgers, Senior Vice President and Chief Marketing Officer of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company which does business as Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma and Texas.

HCSC is the largest customer-owned, non-profit health insurance company in the nation. HCSC is headquartered in Chicago, Illinois with a workforce of nearly 20,000 employees serving nearly 14 million members throughout our five-state Blue Cross and Blue Shield plans.

HCSC'S Individual Consumer and Small Employer Business

For over 80 years, HCSC has been committed to expanding access to cost-effective health care to as many people as possible in every part of our five states. Whether through employer-sponsored insurance, government programs or individual products, HCSC is committed to its purpose and to offering our customers a wide range of cost-effective and sustainable product choices to meet their health and wellness needs.

As we transition to a new health care marketplace, HCSC remains committed to its individual and small employer market and to continuing to offer accessible products, particularly to those individuals who do not have access to employer sponsored coverage, are self-employed or unemployed. We are proud of what our brand stands for—security and peace of mind—and our commitment to the communities in which we operate, as well as our large and geographically diverse network of health care providers and professionals in our operating states. This structure and expertise allow us to offer a variety of affordable product choices in every county of every state in which we operate, to meet our customers' needs.

To support our individual and small employer market, HCSC participated in the health insurance exchanges. We offered a similar portfolio of products (e.g., PPO, HMO), both on and off exchange (i.e., purchased directly through HCSC or a broker) for individuals and small employers with a variety of deductibles, co-pays, coverages and other options, with the goal of meeting our members' diverse health care needs in a way that is understandable and easy to compare.

HCSC's Enrollment Experience

At the current time enrollment and payment information (both on and off exchanges) can only be presented as of each day when the numbers are counted. As such, there are natural lags between the effective date of coverage and the date on which the member's coverage payment may be due. For instance, applicants with policies with an effective date of May 1 may still have time remaining in their payment deadline. In addition, adjustments and reconciliations to this data occurring between the exchanges and HCSC during the implementation process are ongoing and will result in some adjustments to HCSC data. As such, the data HCSC is providing represents our good faith estimate based on our records to date.

With those caveats, HCSC received between October 1, 2013 and April 15, 2014 approximately 830,000 applications across our five states, comprised of approximately 600,000 on-exchange and 230,000 off-exchange applications. We estimate that these 830,000 applications represent coverage for just over 1.2 million applicants.

Currently (and subject to any potential adjustments), HCSC records show the following first payment rates for policies with effective dates starting January 1, 2014:

	1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014
Exchange	85%	86%	88%	83%	68%
Off Exchange	90%	92%	93%	90%	63%

Payment information for May 1 effective date is not yet complete given that payment deadlines for all of those policies may not yet have passed.

Conclusion

HCSC is, and always has been, committed to improving access to and quality of care for all Americans. I thank you on behalf of HCSC for the opportunity to be part of this important ongoing dialogue.

Mr. MURPHY. Now, Mr. Matheis, you are recognized for 5 minutes.

STATEMENT OF DENNIS MATHEIS

Mr. MATHEIS. Chairman Murphy, Ranking Member DeGette and members of the House Energy and Commerce Subcommittee on Oversight and Investigations thank you for the opportunity to be here today on behalf of WellPoint. I am Dennis Matheis, President of the Central Region and Exchange Strategy. I am responsible for creating WellPoint's exchange strategy and overseeing its launch. Prior to my current role, I was President of Anthem Blue Cross and Blue Shield in Missouri.

WellPoint is one of the Nation's leading health benefit companies. We believe that our health connects us all, so we focus on being a valued health partner in delivering quality products and services that give members access to the care they need. With nearly 67 million people served by our affiliated companies, including nearly 37 million enrolled in our family of health plans, we can make a real difference to meet the needs of our diverse constituents.

We are an independent licensee of the Blue Cross and Blue Shield Association. We serve members as the Blue Cross licensee for California, and as the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. In most of these service areas, our plans do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia and Empire Blue Cross and Blue Shield or Empire Blue Cross. We also serve customers in other States through our Amerigroup and CareMore subsidiaries.

WellPoint is currently operating in the federally-facilitated exchange, which includes Georgia, Indiana, Maine, Missouri, New Hampshire, Ohio, Virginia, and Wisconsin. We also participate in several State-based exchanges, including California, Colorado, Connecticut, Kentucky, New York and Nevada.

While there is no doubt that implementation of the exchanges presents a complex and daunting undertaking, we believe we've been able to apply our knowledge and experience to make the system work better for our members. We are seeing strong membership growth and large percentages of our newly-enrolled customers are successfully paying their premiums by the due date.

Our most important priority through all of the complexity of ACA implementation is to ensure that our members receive the best possible care. Working closely and collaboratively with the physician community, our innovative programs from new payment models to telehealth solutions to sophisticated data analytics that arm physicians with better information, we are creating value for our members, for our physicians and for the health care system. We are proud of the work we are doing to transform health care.

WellPoint was pleased to provide the committee last month with enrollment data from October 1, 2013, through April 15, 2014, for States where we participate in the federally-facilitated exchange. As we stated to the committee at the time of submission, this data is not final and only represents a snapshot in time. The data in-

cluded enrollees whose policies have effective dates of April 1, May 1 and June 1, which means that premiums for such policies would not be due until April 10, May 10, and June 10, respectively.

Also, the reported enrollment in premium payment data is subject to adjustments. For example, enrollees may elect to drop their coverage, elect to change the effective date of their coverage after submission of their application, or continue to enroll through special enrollment periods. In response to the committee's request, we submitted the total number of applications received for enrollment in the federally-facilitated exchange during the period of October 1, 2013, through April 15, 2014.

The percentage of applications that have paid a premium will differ depending on whether the percentage is calculated based on the total number of applications and premium payments received during this entire period, roughly 70 percent; or as calculated based on the total number of applications and premium payments received for policies whose premium deadline has passed, ranging up to 90 percent depending on the State.

WellPoint feels privileged to be able to serve our growing community of members. We take great pride in transforming health care with trusting, caring, creative and innovative solutions. I thank the committee for the opportunity to testify today on behalf of WellPoint and look forward to your questions.

Mr. MURPHY. Thank you.

[The prepared statement of Mr. Matheis follows:]

TESTIMONY

PPACA Enrollment and the Insurance Industry

Mr. Dennis Matheis

WellPoint, Inc.

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

U.S. House of Representatives

Wednesday, May 7, 2014

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Mr. MURPHY. For the record, all the witnesses did not go over time, and we'll make sure we fill in the gaps here what has not been provided to us and see if we can get some information.

Do any of you, particularly from the insurance companies—I'm recognizing myself for 5 minutes, by the way—have any data among those people who have subscribed, if the costs they are paying for their overall health insurance plan is more, less, or the same as they were paying in a previous year? Mr. Wingle, do you keep that data?

Mr. WINGLE. I don't have that data available.

Mr. MURPHY. Mr. Evanko, do you know if your plan has that?

Mr. EVANKO. I don't have specific figures to share. I can try to provide some context.

Mr. MURPHY. Would you submit it for the record.

Mr. Rodgers, Mr. Matheis, do your plans keep a record of what people paid in a previous year versus what they're paying now?

Mr. RODGERS. No, I haven't looked at that information.

Mr. MURPHY. Thank you.

And of those who all have signed up for insurance, do any of your companies ask for or have any data if people were among those who had lost their insurance, that is their insurance was canceled because of change in the Affordable Care Act? Any of you from insurance companies, do any of you have that data?

Mr. MATHEIS. We currently do not have that information available.

Mr. MURPHY. OK. All right. Thank you.

So we don't know if the people who were signing up with these health insurance plans are people who are renewing insurance, had lost insurance or never had insurance, am I correct? Mr. Wingle? Mr. Evanko? Mr. Rodgers? Matheis?

Mr. MATHEIS. That's correct.

Mr. MURPHY. I know Secretary Sebelius said that she did not think we had that data either.

Mr. Wingle, your Chief Executive, Mark Bertolini, said that premium rates in 2015 will range from very low single digits to some that will be over double digits. Can consumers expect this for their 2015 premiums?

Mr. WINGLE. It's important to recognize, first of all, that we're at the start of the rate filing and approval process, so we're very early in the process of establishing those rates and submitting them to State regulators for approval and review. Our rates, it's also important to understand, reflect a number of key factors, most importantly the benefits covered by the plans we're filing, the population covered by those plans and the underlying health care costs in the geographies where those plans are offered. There will be some variability across geography and depending on those circumstances.

Mr. MURPHY. Some might face double-digit increases? We don't know yet, you're saying?

Mr. WINGLE. I can't say for certain whether some will pay double digits, single digits or no increase at all. It's too early to say.

Mr. MURPHY. If there's no increase in insurance, we should all celebrate because I'm not sure that has existed in my lifetime.

Will there be decreases?

Mr. WINGLE. It's hard to say. It will vary by geography and rating factors.

Mr. MURPHY. All right. Mr. Matheis, you announced your quarterly earnings and noted that the ramp-up in the fee of government is charging insurers under the health care law would impact marketplace premiums next year. What can consumers expect?

Mr. MATHEIS. So similar to my colleague's comment, we are in the process of developing our rates now for the 138 rating regions in which we do business across the 14 states. So I don't have exact numbers yet, chairman, in terms of what our rate increases are going to be. Certainly, inputs into that are the experience that we're developing through the population that we're serving, the expected medical trend that's going to occur and then the fees and taxes that occur through the ACA and through State and other Federal constructs, that all goes into the rate construct process.

Mr. MURPHY. I think I'm going down the same hole with each of you, so let me cut to the chase. The bottom line here is, you do get for risk corridors, you do get some money back from the Federal Government to balance out some of your costs, am I correct, with each plan? Mr. Evanko, is that true?

Mr. EVANKO. The risk corridors, as you know, sir, are part of the three Rs. We at Cigna Corporation are not expecting a material, receivable or payable, as it relates to risk corridors.

Mr. MURPHY. My point is that, as we're looking at this data—and we'll continue to monitor and we recognize some of this is still preliminary—based upon who has signed up and what their health care costs are, for example, if you don't reach the 40-percent number that the President had hoped, people between 18 and 35, and mostly those who signed up have been the older and sicker, then that's going to have an impact upon your plan costs. Am I correct, Mr. Rodgers?

Mr. RODGERS. Could you restate that question?

Mr. MURPHY. That if people who have signed up are not the young, healthy invincibles but are indeed the older folks who have preexisting conditions and other health care costs, that you're going to have to face some sort of increase in premiums. Am I correct?

Mr. RODGERS. Well, as two of my colleagues have said, the rates that we file for 2015 haven't been finalized yet, but those will reflect——

Mr. MURPHY. I understand. I am anticipating. You've been in the business for a while.

And the Federal Government does provide some funds for you to help balance these out. Am I correct? Federal money comes to you to help as the risk corridors, and you have other people there who, the increased—costs go up. Am I correct?

Mr. WINGLE. The three Rs program does exist to provide some guard rails. We have not——

Mr. MURPHY. Right. And but over time, that amount of money from the Federal Government will decline. Am I correct?

Mr. WINGLE. Some of those programs are transitional and one's permanent.

Mr. MURPHY. I understand. But we'll get back to this. Thank you.

I yield and now recognize Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. Last week, the majority Republicans on this committee put out a report stating that only 67 percent of the people who signed up for insurance through the State and Federal marketplaces had paid their first month's premiums and then had a big press blitz about that saying that Obamacare had once again failed. So I kind of want to walk some of you through that allegation and see how true it is.

I want to start with you, Mr. Matheis. I believe that the press reports I've seen, the reports from the administration show that through the end of March, which was the deadline, about 8.1 people enrolled through either the Federal or State exchanges. Is that correct, to your knowledge?

Mr. MATHEIS. Did you mean 8.1 million?

Ms. DEGETTE. Yes.

Mr. MATHEIS. Yes. I have the same source of data that you do on that point.

Ms. DEGETTE. That's fine.

Now, in your testimony, you said that the data used in that Republican analysis, quote, included enrollees whose policies have effective dates of April 1, May 1, and June 1. Is that correct?

Mr. MATHEIS. Yes.

Ms. DEGETTE. And that's about 3 million out of 8 million people, about 40 percent. Is that correct?

Mr. MATHEIS. Again, since we didn't enroll all 8 million people, I can't attest to that question or not.

Ms. DEGETTE. But, OK. Well, I will say what I've seen is it's about 3 million out of 8 million. Now, so the 3 million people who enrolled—or let me just say, the people who enrolled in March, they had coverage, in general, that began no earlier than May 1. Is that right?

Mr. MATHEIS. If you enrolled in March, you would have potentially an effective date, depending on what day of the month you enrolled in, could be April 1, could have been May 1.

Ms. DEGETTE. May 1. And so those peoples' premiums were not due until at the earliest, the end of April; is that correct? If you enrolled March 31, your premiums were due at the end of April or later, right?

Mr. MATHEIS. To help facilitate members enrolling, what we have done at WellPoint is actually extended the payment period 10 days beyond the last day of the effective month.

Ms. DEGETTE. So it could be April 30, or it could be even later, correct?

Mr. MATHEIS. So an April 1——

Ms. DEGETTE. Yes or no will work.

Mr. MATHEIS. An April 1 effective——

Ms. DEGETTE. Right.

Mr. MATHEIS. [continuing]. Would actually have until May 10 to pay their premium.

Ms. DEGETTE. OK. Now, Mr. Matheis, let me ask you, your testimony said, while WellPoint ACA's policies whose deadline for paying premiums has passed, about 90 percent have paid their premiums. Is that correct?

Mr. MATHEIS. So our data in our——

Ms. DEGETTE. You can say yes or no. That's what your testimony said.

Mr. MATHEIS. Yes. So it's——

Ms. DEGETTE. OK. Now, that's more than 67 percent. Is that correct?

Mr. MATHEIS. Last time I looked, yes. Greater than 67.

Ms. DEGETTE. Now, Mr. Wingle, let me take you off the hot seat, Mr. Matheis.

Mr. Wingle, I want to ask you, Aetna has shown of the 5- to 600 enrollees who have paid, about 85 percent up until March paid their premiums. Is that correct?

Mr. WINGLE. Our range is in the low- to mid-80s, month to month.

Ms. DEGETTE. OK. And that's also more than 67 percent, isn't it?

Mr. WINGLE. Empirically, yes.

Ms. DEGETTE. Yes.

And Mr. Rodgers, let me ask you, for your company, the ACA payment policies whose premium payment deadlines have passed, about 83 to 85 percent of them have paid their premiums; is that correct?

Mr. RODGERS. Yes, except for the most recent month.

Ms. DEGETTE. Right. The ones whose payment deadlines have passed.

Mr. RODGERS. Yes, that is correct.

Ms. DEGETTE. Yes. And that's also more than 67 percent, isn't it?

Mr. RODGERS. That is more than 67 percent.

Ms. DEGETTE. Yes. So what I wanted to ask about is, do any of you expect to see substantially lower payment percentages than you saw historically before the latest enrollment? Mr. Matheis.

Mr. MATHEIS. So I will give a little context to my answer.

Ms. DEGETTE. OK. I need a yes or no. I don't have much time. I'm sorry.

Mr. MATHEIS. Well——

Ms. DEGETTE. Do you expect to see it go down to 67 percent for April?

Mr. MATHEIS. I don't think we have enough information to know exactly where it's going to be.

Ms. DEGETTE. OK. Well, Mr. Rodgers, let me ask you this question, then: Mr. Upton said that he thinks suddenly, maybe they won't pay for their enrollment in March. So I wanted to kind of go through, because you've got a nice chart in your testimony and it shows the payments month by month that people made when they enrolled. So for 1/1/2014 on the exchange, 85 percent of the people paid; is that correct?

Mr. RODGERS. That's correct.

Ms. DEGETTE. For 2/1/2014, 86 percent paid, correct?

Mr. RODGERS. That's correct.

Ms. DEGETTE. For 3/1/2014, 88 percent paid; is that correct?

Mr. RODGERS. Yes.

Ms. DEGETTE. And for 4/1/2014, 83 percent paid; is that correct?

Mr. RODGERS. That is correct.

Ms. DEGETTE. And you're still waiting for everybody else to pay because their deadline has not passed yet; is that correct?

Mr. RODGERS. That's correct.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Mr. MURPHY. Can I just follow up with a clarifying question: When she asked about historical data, were you referring to the last couple months or comparison with previous years under different plans?

Ms. DEGETTE. Well, we didn't have an exchange.

Mr. MURPHY. No, no, I just——

Ms. DEGETTE. Chairman, we only just got the exchange.

Mr. MURPHY. No, I wasn't sure if you meant under historical you mean previous years of plans versus just the exchange.

Ms. DEGETTE. Mr. Chairman, what I mean is since the ACA was implemented starting on October 1.

Mr. MURPHY. OK. Thank you. I just wanted clarification on that.

Now recognize Ms. Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you all so much for being with us. I want to say with this issue on the premiums because we get asked about this a lot.

So Mr. Wingle, Aetna, your CEO said that premium increases will vary over 17 States and encompass 132 rating areas, correct?

Mr. WINGLE. That is correct.

Mrs. BLACKBURN. OK. Can you identify where premiums will decrease in 2015? What identification can you place on that?

Mr. WINGLE. At this point in the filing season, we can't offer any guidance on or speculate on where they're going to fall. We're still gathering the information for file.

Mrs. BLACKBURN. None?

Mr. WINGLE. I can't say none. I can't say any.

Mrs. BLACKBURN. OK. Mr. Matheis, can you tell me, identify any States where you are offering products in the exchanges where consumers can expect a premium decrease?

Mr. MATHEIS. At this juncture, we do not have the information.

Mrs. BLACKBURN. You don't have the information?

Mr. MATHEIS. No. The filing rates are due starting in late May into June, and so we have not computed yet with any certainty what the actual rates are going to look like in our 138 rating regions.

Mrs. BLACKBURN. OK. A lot of uncertainty floating around out there.

OK, Mr. Evanko.

Mr. EVANKO. I would echo my colleague's comments. We're in the process making decisions. Some decisions on certain assumptions have been made, but most assumptions are still to be determined.

Mrs. BLACKBURN. So you don't know if your consumers are going to see any decreases. You know they were promised decreases through the Affordable Care Act, so.

OK, Mr. Rodgers, to you.

Mr. RODGERS. As the company's marketing officer, I can tell you I'm not involved in rate setting, but I'm aware of some of the deadlines we're facing which are generally toward the end of June.

Mrs. BLACKBURN. OK. Well, let me ask you all this, then: Have any of you conducted any internal analysis of what your organizations premiums are going to look in 2015? Do any of you have any internal analysis? Raise your hand for me. So you all have con-

ducted no—we've got some of our Nation's biggest insurers, and you have done no internal analysis on what the trend line is for these premiums? None?

Mr. EVANKO. Ms. Blackburn——

Mrs. BLACKBURN. Oh, Mr. Evanko, have at it.

Mr. EVANKO. So I'd like to clarify our comments here a little bit, or at least my comments as it relate to this issue. So the decisions related to this are very complicated and they impact each individual a little bit differently because of where someone's located, maybe what their APTC eligibility is, et cetera. So there's a long list of reasons there.

Mrs. BLACKBURN. Right. We understand that. You're talking about a 2,300 page law that became about over 20,000 pages of rules and regulations and we know this changes daily. We appreciate the predicament that you are in. We also appreciate the predicament that our constituents find themselves in.

And it is baffling that we can have some of our Nation's largest insurers and you all don't have any internal analysis as to what these rates are—I thought that, reading your reports, you all did analysis in trend lines for the near-term, the midterm and the long-term and you looked at what the expectations were so that your stakeholders would all be aware of what was happening within that market. You know, has anybody done any kind of analysis?

Mr. MATHEIS. So can I answer your question?

Mrs. BLACKBURN. Yes, please. Have at it, Mr. Matheis. Your mic, please.

Mr. MATHEIS. So analysis is typically ongoing in our organization. Rate development typically takes 3 to 6 months to occur once you have credible information. And so just for context purposes, we, and as has been stated earlier in this meeting——

Mrs. BLACKBURN. Let me——

Mr. MATHEIS. Let me finish.

Mrs. BLACKBURN. OK. Go ahead.

Mr. MATHEIS. [continuing]. We are just now understanding what membership we have attracted and so the work is ongoing, but it has not been finalized. And that's the important point.

Mrs. BLACKBURN. Let me ask you this: What has been prepared for your CEO? Any of you?

Mr. MATHEIS. At this juncture, we do not have a compiled package to sit down and say, here is what we believe a rate is going to be in any of our 130 rate areas.

Mrs. BLACKBURN. When do you expect to have that?

Mr. MATHEIS. Typically, it will be towards the end of this month, as rates need to be filed in our States starting end of May through the June or July time period.

Mrs. BLACKBURN. Would you submit that to us for the record, each of you. Do you agree to submit this for the record so that we will have this?

Mr. WINGLE. And representative, I want to concur with my colleague, we are constantly analyzing our exchange experience. This is a new population. We don't have the long claims record or history we had in the previous market, so the more data we get the better and more confident we feel as we propose rates. It's an ongoing analysis. It's a constant analysis.

Mrs. BLACKBURN. OK. We appreciate that, and we would like to have that analysis and the information you have as you get it and ask that you please stay in touch with us and do those orderly insertions for the record.

I yield back, Mr. Chairman.

Mr. MURPHY. Gentlewoman yields back, and now recognize Mr. Dingell for 5 minutes.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and I thank you for the hearing. I'm pleased the committee is examining the first open enrollment period under the Affordable Care Act. I would like to examine the staff report where it claims only 67 percent of Obamacare enrollees have paid their first month's premium. We want to find out whether that's so and what it means.

The bottom line, I think, is the ACA is working. After a turbulent start we got the Web site up. It's running and HHS now reports that 8 million people have selected plans through the exchanges. Furthermore, some 4.8 million people are enrolled in Medicaid and CHIP, and that number would be much higher if all 50 States chose to expand Medicaid.

CBO estimates that another 5 million people purchased ACA-compliant plans outside the marketplaces. Finally, Gallup just found that the percentage of Americans who do not have health insurance fell to 13.4 percent, down from some 18 percent 1 year ago.

So let's examine and see what goes on.

This question to Mr. Matheis. And "yes" or "no," if you would, please. When WellPoint turned over enrollment figures to the majority, you did this under the caveat that the data was not final and only represented a snapshot in time. Is that correct?

Mr. MATHEIS. Yes, it is.

Mr. DINGELL. Yes?

Mr. MATHEIS. Yes.

Mr. DINGELL. Now, this question, again to you, Mr. Matheis. And that is because the committee only requested data through April 15, 2014; is that correct?

Mr. MATHEIS. Yes, it is.

Mr. DINGELL. Now, Mr. Matheis, is it correct that the people who signed up after May 15 may not have to pay their premium until later in April, May, or even June, yes or no?

Mr. MATHEIS. Is there anybody after April 15th, would have—would have a longer time——

Mr. DINGELL. Those folks who signed up after March 15th.

Mr. MATHEIS. Yes.

Mr. DINGELL. Now, Mr. Matheis, is it correct that nearly 90 percent of WellPoint's customers whose premium deadline has passed have already paid their first month's premium, yes or no?

Mr. MATHEIS. Yes, it is.

Mr. DINGELL. Now, in your experience, have you found that people are more likely to make their premium payment right before the deadline?

Mr. MATHEIS. That is typically human nature, sir.

Mr. DINGELL. And we know that from the behavior of Americans with regard to income tax and things like that.

Now, this question is for Mr. Wingle of Aetna. Is it correct that, according to your best estimate, roughly 80 percent of Aetna beneficiaries who have reached their payment due date have paid their first month's premium, yes or no?

Mr. WINGLE. Month to month, it ranges from the low to mid 80s.

Mr. DINGELL. Say that again?

Mr. WINGLE. It ranges from the low to mid 80s, month by month.

Mr. DINGELL. Thank you.

Now, this question is for you, Mr. Coyne of Blue Cross-Blue Shield. Is it correct that, according to your best estimate, 80 to 85 percent of the individuals buying Blue Cross-Blue Shield plans through the marketplace have paid their first month's premiums, yes or no?

Mr. COYNE. Yes, that is correct.

Mr. DINGELL. I'm not hearing you, sir.

Mr. COYNE. Yes, that is correct, based on——

Mr. DINGELL. That's correct.

Mr. COYNE. [continuing]. A report we——

Mr. DINGELL. Now, gentlemen, it doesn't take, I think, a genius or an atomic physicist to figure out the numbers we just heard from the actual insurance companies greatly differ from the staff report. I hope everyone will take these companies at their word instead of falling for smoke and mirrors from my friends on the other side of the aisle.

I can understand why my friends on the other side of the aisle are not in attendance, because they would get a very unpleasant taste of fact which they might not like. My old daddy taught me, he used to say to me, "Son, figures don't lie, but liars can figure."

And I have always thought that it would be a good thing, when this committee does its business, that we know what we are doing, that we deal in hard facts, so that when the legislation that we work on, the laws that we are dealing with, the oversight in which we engage actually lead us to truth and correct response, so that public policies may be founded on fact rather than fiction and on staff reports that mislead all.

I would suggest that the staff report should be reviewed with the utmost of care and deposited then very carefully in the nearest large wastebasket.

Thank you, Mr. Chairman.

Mr. MURPHY. The gentleman yields back.

I now recognize the Vice Chair of the committee, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. I thank you for the recognition.

I would remind the chairman emeritus that we are friends.

Let me ask you a question. April 17th, the day the President came out with his "mission accomplished" speech at the White House in the press briefing, there was a briefing of executives of your companies; is that correct?

Anyone is free to answer.

Mr. MATHEIS. I believe that was correct, sir.

Mr. RODGERS. That is correct, yes.

Mr. BURGESS. And was your company represented?

Mr. RODGERS. I'm not sure which particular meeting you're describing, but I know there have been some.

Mr. BURGESS. Well, let me give you the particular meeting. It was on April the 17th at 1:35 p.m., the President and Vice President meet with insurance executives in the Roosevelt Room.

Did that meeting take place?

Mr. MATHEIS. WellPoint was present at that meeting, sir.

Mr. BURGESS. WellPoint was present.

Was Cigna present?

Mr. EVANKO. Our CEO was not present at that meeting.

Mr. BURGESS. Your—was not. OK.

Mr. WINGLE. I'm advised that our CEO was not present at that meeting.

Mr. BURGESS. That was Blue Cross?

Mr. WINGLE. That's Aetna for me.

Mr. BURGESS. Was Blue Cross represented at the meeting?

Mr. COYNE. I don't have that information right now.

Mr. BURGESS. Well, for those that were——

Mr. PRATT. And just for the record, I'm advised that AHIP's President was present at the meeting.

Mr. RODGERS. And I don't—I can't remember the exact date of those meetings, but I can tell you that when we are called to the White House, generally we would attempt to be there.

Mr. BURGESS. Well, it was April 17th. I mean, I would think you'd remember. It's a pretty big deal. I mean, I haven't had a meeting with the President or the Vice President.

Ms. DEGETTE. Would the gentleman yield? Perhaps——

Mr. BURGESS. No, I will not. No, I will not. My time is limited.

What I would like, from those that answered affirmatively, Mr. Matheis and Mr. Pratt, can you provide us information as to what was covered in that meeting—who made the presentation, how long it was? And was there, in fact, time for there to be question and answer, or was it simply a presentation to you from the President and Vice President?

Mr. MATHEIS. Mr. Congressman, I was not personally present at that meeting, our CEO was, and I do not know the facts of the meeting.

Mr. BURGESS. Would you make an attempt to answer for me those questions? Was this an interactive process, or was this a proclamation? Was it a monologue, or was it a dialogue?

And, Mr. Pratt, if you would provide us that information, as well.

And here is the deal. I mean, why am I making a big deal of this? You all are here today because the White House won't respond to us. And I would think, if it was possible for the White House to provide a briefing to your executives on April 17th, that same person could be made available to this committee and be prepared to answer our questions. I don't see what is so difficult about that. If the news is as great as everyone has said it is this morning, I think that they would welcome the opportunity to come to our committee and give us the information that we are asking for.

Look, one of the questions that I raised in the opening statement, and I do want your answers on this because it is important, this 90-day grace period and the coverage that can't be cancelled during that 90-day grace period because of nonpayment. Is there any way

for any of your individual companies to keep up with that information on a rolling basis and keep your providers informed as to the status of a person's payment or nonpayment of their premium?

We'll start with you, Mr. Coyne, and let's just work down the table.

Mr. COYNE. We are working with Blue Plans to inform providers of the enrollee's status, as you indicated.

Mr. BURGESS. Mr. Wingle?

Mr. WINGLE. Yes. We do have a unique identifier for our exchange membership on the ID card, and we do provide updates on the member's payment status in our physician information centers. So when the physician offices call or the provider calls, they understand what the payment status is of the member.

Mr. BURGESS. Mr. Evanko?

Mr. EVANKO. Our doctors and our hospitals that are servicing our customers have the ability to either call or check online the status of the individual's payment grace-period situation.

Mr. BURGESS. And, Mr. Rodgers, would that even pertain to you?

Mr. RODGERS. Yes. Similarly, we have electronic means as well as a telephone service for providers of various types to verify coverage.

Mr. BURGESS. And Mr. Matheis?

Mr. MATHEIS. Yes, we provide the same service.

Mr. BURGESS. And what I would ask of each of you is, will you make available to the committee the type of information and how it is transferred to your providers, your doctors and hospitals, when they call for that information?

And then, Mr. Chairman, further, I would like to ask unanimous consent—the Secretary was here in December, the Secretary of Health and Human Services. After that hearing, I submitted a letter to the Secretary with several questions that I wanted answered. They have not been answered to date.

I am going to ask those same questions of our insurance representatives today. I am going to ask those in writing, and I would appreciate your response to those questions that the Secretary was unwilling to answer.

Ms. DEGETTE. Reserving the right to object. I would just point out that the Secretary was here in front of this committee testifying three times last year. And if there are questions she has not answered, we certainly will be happy to work with the majority and get those questions answered.

Mr. MURPHY. Well, the Members do have the right to——

Ms. DEGETTE. I will drop my reservation.

Mr. MURPHY. [continuing]. Submit questions for panelists.

Mr. BURGESS. And I will be submitting those questions in writing for our panel.

Thank you, Mr. Chairman.

Mr. MURPHY. Mr. Green, you are now recognized for 5 minutes.

Mr. GREEN. Thank you, Chairman Murphy and Ranking Member DeGette, for having this hearing today, and our witnesses for the testimony.

My district in Texas is a very urban district in Houston and has one of the highest rates of uninsured people who don't receive insurance through their employer in the country.

One of the other talking points that my Republican colleagues have seized upon last year, especially when the HealthCare.gov was encountering problems early in the enrollment period, was the idea that fewer people would have health insurance following the implementation of the Affordable Care Act than did beforehand.

Now, I know that all our representatives here today see that the information and how many people they have enrolled and their total number of customers are proprietary, and I understand that. But you are all also, I would hope, familiar with the general insurance landscape and how it has changed under the Affordable Care Act.

Earlier this week, the Gallup Poll released a survey examining the total number of Americans that have insurance.

Mr. Pratt, are you familiar with that survey?

Mr. PRATT. Generally, yes.

Mr. GREEN. The Gallup Poll conducted interviews with 14,000 American adults. Gallup found that the number of adults without insurance had dropped to its lowest level since the beginning of 2008. A drop of this magnitude correlates to more than 11 million people gaining coverage.

Are you familiar enough with the poll to say that that sounds like a reasonable amount?

Mr. PRATT. Congressman, I think that's what they reported. I'm not in a position to say whether that's a reasonable amount or not.

Mr. GREEN. OK.

Anyone else on the panel want to talk about that Gallup poll? Because, you know, again, these are what we are seeing since the enrollment period ended.

RAND and The Urban Institute released similar reports in March and April. Are any of you familiar with these reports?

Mr. MATHEIS. Just very generally, Congressman.

Mr. EVANKO. I'm not familiar with the reports.

Mr. GREEN. OK. Well, in early April, RAND Corporation released the results of their poll, which found the overall number of Americans with insurance had grown to 9.3 million as of mid-March, even before the late enrollment date surge. The Urban Institute also released a report in the past month suggesting that millions more people have coverage than before the ACA was implemented.

My question of any of our witnesses: Would you agree that the findings of these, whether it be RAND, Gallup, or The Urban Institute, are consistent with millions of Americans signing up for health insurance? Did you all experience that with your companies during the signup, that they selected your company as part of the—if you happened to be part of the exchange, both national or the State exchanges?

Mr. MATHEIS. Congressman, at WellPoint, we do not have enough information at this point to know how many uninsured are actually among the enrollees, because we just don't have access to that data at this point.

Mr. GREEN. OK.

Well, generally, the ACA has led to a huge increase in coverage. Even without the polls, we have seen some of the numbers. And can you verify that with your companies, whether it would be WellPoint, Blue Cross? Have you seen that increase in the number

of people who have signed up with your companies since the deadline?

Mr. RODGERS. Speaking for Healthcare Service Corporation, I provided in my written testimony as well as in my opening comments the number of people that we signed up on- and off-exchange through the open enrollment period. I can't tell you today how many of those came from the ranks of the uninsured or from our competitors or either from a prior policy with one of our five Blue Cross and Blue Shield plans, but we're certainly happy to have the numbers up.

Mr. GREEN. OK.

Well, and we understand there were people who were using the Web sites and the national exchange to shop. And I had some companies who said, I'm a small business, I encourage—in fact, I have a number of them in my area. He said, we have actually helped our employees sign up individually, because, you know, you have 10 employees, they weren't required, but they actually used it. And I know that's an analogy, but I have heard that from a lot of my employers.

Now, I know my Republican colleagues, with the missed data from these polls, that anything that comes through the administration for the overall signup—in March, Speaker Boehner said that there were less people today with health insurance than there were before this law went into effect.

I think, not even basing it on a poll, would you all agree that there are more people that have health insurance now, let's say since May 1st, than we had before the ACA?

Mr. PRATT. I can't speak to numbers on that enrollment.

Mr. GREEN. OK.

I don't know how my colleagues continue to make unfounded claims in the face of the clear evidence that the Affordable Care Act is providing millions of Americans with healthcare coverage. It makes me wonder what would possibly convince them that millions of Americans have gained coverage under the law. I suspect that, ultimately, once the information becomes so indisputable, that it maybe will change the subject and, rather, concede that clearly more people have health insurance as a result of the ACA.

And having served many years in Congress and even before that in the State legislature in Texas, no law Congress ever passes is perfect. That's not how our forefathers created the system. So we do need to go back, like our ranking member said, and see what we can do to fix the ACA. And I appreciate you all's efforts to help us do that once we get to that point.

And I will yield back my time.

Mr. MURPHY. The gentleman yields back.

I now recognize Mr. Griffith of Virginia for 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman.

Thank you all for being here.

Ms. Blackburn asked you earlier for a show of hands, and I am going to do the same. If your company anticipates a reduction for the average family that you insure of $2,500 or more, would you raise your hand?

If your company anticipates a reduction in premium of $2,000 per average family for your subscribers, raise your hand.

Same for $1,500?

All right. I appreciate that.

When will your companies submit their rates to the administration for 2015? Do you all have a date that you're going to do that by? We'll start with——

Mr. RODGERS. I believe the——

Mr. GRIFFITH. Yes?

Mr. RODGERS. [continuing]. Rates are due toward the end of June. I believe it's June 27th. I think that some of the States are a little bit ahead of that.

Mr. GRIFFITH. All right. And do you know when those will become public?

Mr. MATHEIS. Depending on the market, sir, that will vary, depending on the States.

Mr. GRIFFITH. All right.

And when you submit those to the administration, will you commit today to submitting those rates to us, as well?

Mr. RODGERS. I'm not involved in the rate submission process, but to the extent that's possible—I'll need to talk with our company representatives about that.

Mr. GRIFFITH. Well, I certainly can't see how it would be illegal to share information with the United States Congress, but——

Mr. RODGERS. I didn't say "illegal."

Mr. GRIFFITH. But if possible, you will do it, Mr. Rodgers?

Mr. RODGERS. I need to confirm with our actuaries who are involved in the rate-filing process, because I'm not.

Mr. MATHEIS. We are happy to work with this committee as long as the rates remain proprietary until they do become public and all of our competitors see them.

Mr. GRIFFITH. All right. That's certainly fair.

Any others?

Mr. Wingle?

Mr. WINGLE. I'd have to take that under advisement about how we share rates.

Mr. GRIFFITH. Mr. Evanko?

Mr. EVANKO. I'd just say that the rates are very competitively sensitive, for obvious reasons. So we want to make sure that it's a level playing field at the time any rates are disclosed.

Mr. GRIFFITH. Have either you or anyone in your organizations—and, again, it's for all of you all—engaged in discussions with the administration already about the 2015 rates?

Mr. RODGERS. Not that I'm aware of.

Mr. WINGLE. Not to my knowledge.

Mr. GRIFFITH. Everyone is silent. Does that mean there have been none? Has anyone had any discussions with the administration about rates for 2015?

Mr. MATHEIS. None that I'm aware of.

Mr. GRIFFITH. OK.

Mr. EVANKO. No.

Mr. RODGERS. No.

Mr. GRIFFITH. All right. Appreciate that. Thank you very much.

Mr. Pratt, the ACA includes a tax credit for small businesses to purchase health insurance coverage for employees. The law also levies a tax on health insurance purchased by small businesses.

On the one hand, we give employers a tax credit to make health insurance more affordable, and then we turn around with the other hand and we tax those policies. Does that not seem as an inherent conflict in policy to you?

Mr. PRATT. Congressman, we have expressed significant concerns with the new tax on small businesses and individuals that total some $100 billion that will largely be passed on to them in the form of higher premiums.

Mr. GRIFFITH. And what we are trying to do, of course, is to see if we can't keep premiums down. And the ACA, Obamacare, has failed to meet its promise of a $2,500 reduction for the average family. That's pretty straightforward, isn't it?

Mr. PRATT. Congressman, we do believe that the health insurance tax runs counter to the goal of providing more affordable coverage.

Mr. GRIFFITH. And as a part of this, we are actually taxing government itself. We've got Federal programs, including Medicare Advantage, Medicaid Managed Care. The Federal Government is, in fact, taxing itself with the tax that you spoke of earlier through its subsidization of Medicare and, in part, Medicaid. And then State governments are also having to pay the tax.

Do you have any idea how much that tax is on the American people? You said $100 billion in increase, but how much for the Federal and State governments?

Mr. PRATT. Congressman, I don't have that information handy. But we did commission a study by Oliver Wyman that does break out that information in more detail, including on a State-by-State basis, and we'd be happy to make that available.

Mr. GRIFFITH. All right. I appreciate that, if you would.

Also, in your testimony, you write that insurers have many duplicate enrollments because of the problems with HealthCare.gov. And I can tell you that we had that in both—I have heard it from constituents and in our family. Apparently, we didn't push the right button the first time around. I say "we"; my wife did it all. Don't want to take on any assumptions that it was us doing it; it was my wife working over the computer for hours and hours. But actually submitted several different applications, ended up with one.

How widespread is that problem for citizens out there? And is that part of the confusion between whether or not people have paid their premiums or not?

Mr. PRATT. Congressman, the challenge you referred to, I think, was presented as a result of the problems with the Web site and the technology. And, anecdotally, we have heard from our members about a number of duplicate enrollments. Don't have an order of magnitude on that other than to know that it has been a problem and an issue.

Mr. GRIFFITH. All right. I appreciate that.

And, Mr. Chairman, I yield back.

Mr. MURPHY. The gentleman yields back.

I now recognize Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

This morning, the Democratic committee staff released a memorandum on the amazing number of distortions and false claims that

Republicans have made about the Affordable Care Act. It's a deplorable record. Virtually every major prediction or claim made by the Republicans about the ACA since 2009 turned out to be wrong.

Today, we have the benefit of hearing from some of the companies that are actually working on the Affordable Care Act in the real world. These companies were not the biggest supporters of the law, they still oppose many provisions, but they do not live in the Republican echo chamber, they live in the real world. And I hope they can provide some clarity on a few questions.

The first question I have for all of you is whether the ACA is a government takeover of health care.

Republicans have made that claim I don't know how many times. By one count, the phrase appeared on Speaker Boehner's Web site 90 different places. It's mentioned on the RNC, Republican National Committee, Web site 200 times. Days before the Affordable Care Act's passage in 2010, then-House-Minority-Leader John Boehner's office wrote that, quote, "Democrats have opted for a government takeover of health care."

So, Mr. Wingle, the ACA is now in effect. Has the government nationalized Aetna, or is it still a for-profit corporation?

Mr. WINGLE. We are a publically traded, for-profit corporation.

Ms. SCHAKOWSKY. And, Mr. Evanko, what about you? Has Cigna been taken over by the Federal Government?

Mr. EVANKO. No. We're a for-profit organization.

Ms. SCHAKOWSKY. Mr. Rodgers, Mr. Matheis, have your companies been nationalized, or are they still nonprofits?

Mr. RODGERS. We are a not-for-profit, mutual legal reserve company.

Mr. MATHEIS. And we are actually a for-profit organization.

Ms. SCHAKOWSKY. Oh, you're a for-profit. Sorry.

Mr. Pratt, you work for the trade group that represents the private insurance industry. Is there still a private insurance industry, or has the industry been destroyed or taken over by the government, as Republicans predicted?

Mr. PRATT. There is still a private industry, and we represent many of those companies.

Ms. SCHAKOWSKY. Thank you.

Republicans also questioned whether private health insurance would even exist in 2014. In 2010, Senator Coburn said, quote, "There will be no insurance industry left in 3 years," and that, quote, "Private health insurance will be dead in 3 years," unquote. I should note that nearly 4 years have passed since that statement was made.

Mr. Pratt, is the private health industry dead?

Mr. PRATT. Representative, no.

Ms. SCHAKOWSKY. Does anybody else on the panel believe the private industry has disappeared, private insurance industry?

Thank you.

Republicans have also claimed that Americans will no longer be able to see their doctors because of the ACA.

Mr. Wingle, does your company healthcare plan—do the plans cover physician care?

Mr. WINGLE. They do.

Ms. SCHAKOWSKY. And, Mr. Evanko, what about you? Does Cigna have doctors in its healthcare plans?

Mr. EVANKO. Yes, we do.

Ms. SCHAKOWSKY. Mr. Rodgers, what about HCSC? Do you include doctors in your networks?

Mr. RODGERS. Certainly.

Ms. SCHAKOWSKY. And, Mr. Matheis, what about WellPoint?

Mr. MATHEIS. Yes, we cover physician services.

Ms. SCHAKOWSKY. Thank you. Thank you very much.

Republicans have claimed that nobody would sign up for coverage. They've claimed that huge numbers have not paid for coverage. Eight million people have signed up for coverage on the exchanges. Millions more have coverage outside the exchanges. And each of the insurance companies here today have testified that people have signed up in droves and upwards of 80 or 90 percent have paid their premiums.

Mr. Chairman, I don't know if there will ever come a day when Republicans will admit their criticisms of the ACA have been unfounded. I think we may have reached a turning point last week when you released your misleading report on the Affordable Care Act enrollment. I think the American public finally realize that Republicans have absolutely no credibility on this issue. You cannot be this wrong this many times and still expect to be taken seriously.

One commentator, Ezra Klein, even gave the Republican behavior a name: Obamacare Derangement Syndrome. He defined it as, and I quote, "the acute inability to see Obamacare as anything but a catastrophic failure that the American people will soon reject. For those suffering from ODS, all bad Obamacare news is good news and all good Obamacare news is spin. In this world, delays of minor provisions in the law prove that the entire structure is collapsing, while surges of millions of people enrolling in insurance don't prove anything at all."

Mr. Chairman, perhaps we can ask our panel of insurers if their policies cover Obamacare Derangement Syndrome. But, really, that's rhetorical.

And I yield back. Thank you.

Mr. MURPHY. But it would be important to know if that's a preexisting condition, and I think it's not coverable——

Ms. DEGETTE. It would be covered now. Good news, Mr. Chairman.

Mr. MURPHY. It depends what the death panel says, I think.

Mr. Olson is now recognized for 5 minutes.

Mr. OLSON. I thank the chair.

And welcome to our witnesses.

I wish you weren't here, but you are here. You're here because the administration will not give us the information we need to educate our constituents about Obamacare and the rollout of HealthCare.gov.

I want to talk about, all of you, a question about the back end and the money you're supposed to be getting from the exchange and the information. In your experiences, is it working?

Mr. Pratt, is the back end working? Are you getting what you need from HealthCare.gov?

Mr. PRATT. Representative, throughout the open enrollment period, we worked very closely to develop workarounds, manual processes, and other things that were necessary to make the system work better. It's my understanding that, while the back-end problems have improved, some remain.

Mr. OLSON. Workarounds. You guys stepped up to the plate to work around the disaster of the healthcare exchange rollout? Is that what you're trying to say?

I mean, you guys took it upon yourself instead of depending on what—they've got information. You depend upon them. And is sort of trickling down and just coming out slowly, slowly, slowly not what you need? Is that you're saying? You guys stepped around to make that happen?

Mr. PRATT. Representative, I think what I would say is that we kept the interests of our members squarely in mind, in terms of minimizing disruption for them. And our members did what was necessary to make sure that it was as smooth as it possibly could be.

Mr. OLSON. Mr. Coyne?

Mr. COYNE. I would agree with Mr. Pratt. There are still back-end issues to be worked through but that we are working with CMS on those. CMS has called a meeting of health insurers in the Federal marketplace on May 20th to consider some of those back-end issues and try and find solutions to them.

Mr. OLSON. And I hope you keep us advised of what that meeting puts forth, give us that information. Because we are not getting it from the Obama administration.

Mr. Wingle?

Mr. WINGLE. We've worked closely to share our concerns about technical needs and help work with the industry, through our trade association, with colleagues to recommend prioritization on fixes for back-end issues, whether they're data cleanup issues or other issues related to the back end of the exchange.

Mr. OLSON. Mr. Evanko?

Mr. EVANKO. There are certainly more manual processes than we anticipated prior to the exchanges launching. I'd say there have been improvements in some areas. The one back-end issue that we are most focused on is the APTC payments coming from CMS to us as a carrier. That's a manual process today. We have been getting the payments we've been requesting, though, as it relates to APTC.

Mr. OLSON. Manual process. Twenty-first century, manual process.

Mr. Rodgers?

Mr. RODGERS. We're continuing to work with the enrollment process to make sure that any of the members that have selected one of our five Blue Cross and Blue Shield plans get the information they need from us and ultimately the care they need.

Mr. OLSON. Mr. Matheis?

Mr. MATHEIS. Yes. We've seen significant improvement, but we still have a number of opportunities for improvement as we move through the remainder of this year.

Mr. OLSON. And one final question for all the panelists. Is the Web site fixed?

Mr. Pratt?

If it's not fixed, when it will be fixed?

Mr. PRATT. Representative, I don't work in the operations area. I think if the back-end issues are considered part of the Web site, I would say——

Mr. OLSON. They are.

Mr. PRATT. [continuing]. Yes, that there are still issues outstanding that we're working on.

Mr. OLSON. Not fixed.

Mr. Coyne?

Mr. COYNE. There are still issues on the back end.

Mr. OLSON. Another one not fixed.

Mr. Wingle?

Mr. WINGLE. There's still work to be done.

Mr. OLSON. Not fixed.

Mr. Evanko?

Mr. EVANKO. I can't comment on the end-to-end process. I can only comment on the component when CMS sends us enrollment transactions, and there is still work to do before that's 100 percent.

Mr. OLSON. Not fixed.

Mr. Rodgers?

Mr. RODGERS. Yes. We are still working with the files that we get, and I think there could be some improvement.

Mr. OLSON. Still not fixed.

Mr. Matheis?

Mr. MATHEIS. Yes. I echo my colleagues' statements. We still have opportunities for improvement.

Mr. OLSON. Six for six. All not fixed.

Mr. Chairman, I yield back the balance of my time.

Mr. MURPHY. The gentleman yields back.

I now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair.

So much of the debate we have with our Republican colleagues about the Affordable Care Act comes down to one simple question: Is it a good thing for Americans to have access to quality health insurance?

You would think this is a simple question. Every Republican member of the committee has health insurance. I bet that every pundit who makes a living attacking the ACA has health insurance. They all make certain their children have health insurance. I bet they wouldn't dream of going without it for an extended period of time.

Two big reasons these people make sure they have coverage is that it can help them stay healthy and it can prevent catastrophic medical bills that can lead to financial ruin. But, this week, we got clear evidence from Massachusetts that health insurance actually saves lives. Researchers at the Harvard School of Public Health looked at mortality rates in Massachusetts and in surrounding States.

My question, Mr. Pratt, is that, in 2006, Massachusetts passed major health reform legislation; is that not correct?

Mr. PRATT. Yes, that's correct.

Mr. TONKO. And did that coverage expansion bear some significant similarities to the Affordable Care Act, including an individual mandate, expanded Medicaid coverage, and insurance exchanges?

Mr. PRATT. Generally, I would say that's fair to say.

Mr. TONKO. Thank you.

The Harvard researchers found that, following healthcare reform in Massachusetts, mortality rates dropped significantly compared to surrounding States. The death rate from treatable illnesses like cancer and heart disease declined even faster.

These findings are truly remarkable. Nearly a 5 percent drop in mortality from preventable illnesses. They found that for every 830 individuals who gained coverage, 1 life was saved. Extrapolating that onto the national scene, if the trend holds, it means that ACA will save tens of thousands of lives.

I'm not going to ask the witnesses to comment on the specifics of that study, but these witnesses know the value that health insurance provides.

Mr. Matheis, do you have any doubt that your health insurance plans cover lifesaving treatments?

Mr. MATHEIS. No, they do, sir.

Mr. TONKO. Mr. Evanko, what about you? Do you help members access lifesaving treatments?

Mr. EVANKO. Absolutely.

Mr. TONKO. Thank you.

And, Mr. Rodgers, Mr. Wingle, what about your plans?

Mr. WINGLE. As a healthcare company, we are proud of providing consumers with high-quality plans competitively priced. We are very proud of that.

Mr. RODGERS. Yes, sir, I agree.

Mr. TONKO. Thank you for your affirmative answers. Thank you.

I think Republicans are really outside of the mainstream when they try to argue that Americans aren't better off if they have health insurance coverage. Their tireless efforts to discourage people from getting covered are truly shameful.

Even more shameful is the refusal of Republican Governors and some legislatures to expand the Medicaid program. Doing that would provide millions of Americans with healthcare coverage, and the Harvard study indicates that doing so would save thousands of lives.

So we thank you for your affirmative answers.

I yield back.

Mr. MURPHY. The gentleman yields back.

I now recognize Mr. Gardner for 5 minutes.

Mr. GARDNER. Thank you, Mr. Chairman.

And thank you to the witnesses for being here today and your time.

Last year, the President apologized for his broken promise, if you like your plan, you can keep your plan, after millions of Americans received plan cancellations.

I'd like each insurer to reply in turn, how many plans did you cancel or discontinue last year because of Obamacare?

Mr. Coyne?

Mr. COYNE. We don't have that information at the association. Individual health plans have that information.

Mr. GARDNER. Mr. Wingle?

Mr. WINGLE. We can provide that information to the committee.

Mr. GARDNER. Could you submit that for the record, and by State, with the total for all of you?

Mr. Evanko?

Mr. EVANKO. Sure. Yes.

Mr. GARDNER. Do you have the number off the top of your head right now?

Mr. EVANKO. I can give you approximations and——

Mr. GARDNER. Sure. That would be great.

Mr. EVANKO. We had approximately 2,000 customers, individual customers, in South Carolina and Connecticut.

Mr. GARDNER. Mr. Wingle?

Mr. WINGLE. Again, we'd want to get you the firm data.

Mr. GARDNER. OK.

Mr. Rodgers?

Mr. RODGERS. I don't have that data with me. I think we've provided it to other congressional committees, so we'd certainly be happy to——

Mr. GARDNER. But that's not a number that you keep on the top of your head?

Mr. RODGERS. Not at all.

Mr. GARDNER. OK.

Mr. Matheis?

Mr. MATHEIS. I don't have the number of products off the top of my head, but we'd be happy to find that out.

Mr. GARDNER. If you could submit for the record by State and what the total, I would appreciate it.

And then, to AHIP, does your organization know how many plan cancellations there were nationwide last year, or for your members?

Mr. PRATT. Congressman, we would not have that information.

Mr. GARDNER. You don't ask that of your members, or they don't provide that to you?

Mr. PRATT. To my knowledge, we do not, no.

Mr. GARDNER. OK.

Mr. Coyne, does your organization know how many member plans were canceled? You don't?

Mr. COYNE. We haven't asked for that information either.

Mr. GARDNER. In order to avoid these cancellations, some insurers offered early renewal plans so they could continue into 2014. If each of the insurers could reply in turn, how many plans did you offer early renewals to last year that would have been otherwise cancelled?

Mr. Matheis?

Mr. MATHEIS. We offered early renewals to all of our customers in all 14 States that was allowable. So California did not allow us to offer early renewal, but in the majority of every other market we offered it to every customer.

Mr. GARDNER. Mr. Rodgers?

Mr. RODGERS. We offered early renewals in four of our five States. The Montana plan became part of our larger——

Mr. GARDNER. And how were those offers? How many offers were there?

Mr. RODGERS. I don't have the number with me, but they're significant numbers, yes. And——

Mr. GARDNER. Could all of you provide those for the record and by State, breaking it down, please?

Mr. Evanko?

Mr. EVANKO. Yes. We offered early renewal to about 235,000 customers in all States except for Connecticut and South Carolina, as I t estified earlier.

Mr. GARDNER. OK.

And Mr. Wingle?

Mr. WINGLE. We offered early renewals as consistent with State laws and regulations.

Mr. GARDNER. OK.

Last year, President Obama apologized for these canceled plans and offered a 1-year delay of enforcing the Obamacare requirements that led to the cancellations. This delay has since been extended.

I'd like each insurer to answer: How many plans do you currently offer that do not meet the law's requirements but you are able to continue offering because of this delay?

Mr. Matheis?

Mr. MATHEIS. I would have to get you that number, sir. I don't know it off the top of my head.

Mr. GARDNER. Mr. Rodgers?

Mr. RODGERS. Yes, I don't know the number.

Mr. GARDNER. Mr. Evanko?

Mr. EVANKO. I don't know the exact figure either.

Mr. GARDNER. Mr. Wingle?

Mr. WINGLE. I don't have the hard numbers on the pre-ACA plans.

Mr. GARDNER. To AHIP, do you know how many plans your member organizations currently offer under this delay?

Mr. PRATT. Could you please repeat that question, Congressman?

Mr. GARDNER. The question is the 1-year delay of enforcing Obamacare requirements that led to the cancellation, this delay has been extended. How many plans do you currently offer that do not meet the law's requirements but you're able to continue offering because of this delay?

Mr. PRATT. I don't have that information.

Mr. GARDNER. You don't have that number.

Mr. Coyne?

Mr. COYNE. The only information we have has been informally reported to us, and it contains all non-ACA-compliant plans across the Blue system. And that number is 3.2 million.

Mr. GARDNER. Yes.

Mr. Matheis, what happens with those plans when the time runs out, when the delay expires?

Mr. MATHEIS. So, depending on how the State handles it, with the extension, in theory a customer could sign up for 2 more years——

Mr. GARDNER. What happens after that time expires?

Mr. MATHEIS. Then they would be——

Mr. GARDNER. Canceled?

Mr. MATHEIS. [continuing]. Moved to an ACA product.

Mr. GARDNER. So that plan would be canceled?

Mr. MATHEIS. Yes, sir.

Mr. GARDNER. Mr. Rodgers, would that plan be canceled at the end of the time period?

Mr. RODGERS. Mr. Matheis' characterization was correct, I believe.

Mr. GARDNER. So, yes, that's a cancellation after the time expires.

Mr. Evanko, would those plans be canceled after the time expired?

Mr. EVANKO. Based on the current guidance, yes.

Mr. GARDNER. Mr. Wingle, would those plans be canceled after the time expires?

Mr. WINGLE. Where feasible, we would offer the member an ACA-compliant alternative.

Mr. GARDNER. Could you submit the total numbers for all of those plans that would be canceled when the time expires and break it down by State, please?

Thank you.

And one of the excuses that we've heard from the supporters of the healthcare bill is that the law didn't do this, didn't cause the cancellations, that you were the ones who planned the cancellations and planned all of the cancellations.

Were the massive cancellation notices sent last year, the ones the President apologized for, were these because of Obamacare or because of you?

Mr. Matheis?

Mr. MATHEIS. The law required us to send out those cancellations.

Mr. GARDNER. So Obamacare required the cancellations.

Mr. MATHEIS. Yes.

Mr. GARDNER. Mr. Rodgers?

Mr. RODGERS. The law required us to, in certain situations——

Mr. GARDNER. So Obamacare caused and required the cancellations.

Mr. Evanko?

Mr. EVANKO. We had such a small fraction of our book of business that was not offered early renewals. But that was——

Mr. GARDNER. But Obamacare required the 2,000 cancellations that you said?

Mr. EVANKO. In the two States where we did not offer early renewals.

Mr. GARDNER. Mr. Wingle, did Obamacare cause the cancellations?

Mr. WINGLE. Plans that weren't compliant with the benefit requirements of the law were canceled.

Mr. GARDNER. So that's a yes?

Mr. WINGLE. That is a yes.

Mr. GARDNER. In attempting to pass this law, the President said repeatedly, if you like your plan, you can keep it. Did that turn out to be true for all of your customers?

Mr. Matheis?

Mr. MATHEIS. No, that was not true for 100 percent of our customers.

Mr. GARDNER. Mr. Rodgers?
Ms. DEGETTE. Time's over.
Mr. RODGERS. Not for 100 percent.
Mr. GARDNER. Mr. Evanko?
Mr. EVANKO. For over 99 percent of our customers, that was the case.
Mr. GARDNER. Mr. Wingle?
Mr. WINGLE. Not in all cases, no.
Mr. GARDNER. OK. Appreciate your time.
And I yield back.
Mr. MURPHY. Thank you.
I now recognize Ms. Castor for 5 minutes.
Ms. CASTOR. Well, thank you very much. And good morning.
And thank you, Mr. Chairman, for calling this hearing to discuss the strong enrollment numbers of the Affordable Care Act.
When the enrollment numbers were released last week, coming from the State of Florida, we were floored. About 1 million Floridians signed up under the Affordable Care Act. This far exceeded our expectations. We thought 600,000, 700,000, but to get to about a million signed up that doesn't include the about 300,000 children that signed up under children's health insurance or our disabled neighbors or children under Medicaid.
And then I learned from our Florida Blue executives Friday—Florida Blue is the market leader in Florida—that that million-dollar figure does not include others that signed up with private health insurance companies, so let's add on another probably couple hundred thousand. It's really remarkable, and it has far exceeded our expectations.
I just think about all of my neighbors all across the State that are breathing easier because now they have financial security in their lives that they did not have before.
And I want to thank all of our navigators, the insurance brokers, many of the insurance companies that were out providing information, all of our community outreach partners. You have made a fundamental difference in the lives of millions of Floridians, and it's going to be very meaningful for them and their families.
It's also good news for neighbors that have insurance already. Most people across America already have insurance, and if you have insurance, what you want most of all is that you want other people to have insurance. Because the cost of these high premium increases and rate increases over time were largely caused by this huge uninsured population. And those costs, when they show up at the hospital for health care, they have to be paid somewhere. So that's what we're hoping then.
And we've heard time and time again the scare tactics here, and we'll see what happens with premium increases, but do we want to go back to the double-digit consistent premium increases of the past? I don't think so. So this is a way that, hopefully, over time we will be able to stabilize the marketplace.
And I think my colleague, Congressman Tonko, was right. I think my Republican friends now are in danger of sounding like they are opposed to people taking personal responsibility and having health insurance. People need to have health insurance to maintain their quality of life, to make sure they don't go bankrupt.

And I would hope that my Republican friends could now turn the page and we could get to work on many of the complicated issues with health policy in America.

Now, one of my Republican colleagues' favorite attacks on healthcare reform is that it will cause people to lose their doctors. Now, you have to say, OK, even in Florida, where you have over a million people that now have health insurance, they're going to be able to see a doctor, 8 million nationwide. But this is especially bizarre coming from Republicans, because they have long opposed any policy proposals to broaden networks. They have fought efforts to increase reimbursement for primary care providers who serve Medicare and Medicaid patients.

What has been lost in this debate is the fact that the ACA sets important new network adequacy standards that guarantee access to key essential community providers. It ensures that no consumer will ever see a huge out-of-network bill if they're taken to an emergency room. And it gives consumers strong appeal rights. It's a huge step forward in patient access.

Mr. Pratt, can you give us some context here? Providers and insurance regularly negotiate rates and determine who will be inside of a network; isn't that correct?

Mr. PRATT. Representative, yes, that's correct.

Ms. CASTOR. And if insurers had to include every provider in their network, wouldn't that eliminate their bargaining power and substantially increase premiums?

Mr. PRATT. Congresswoman, I think that is generally correct. I wouldn't characterize the amount of the increase, but it is a very important aspect of keeping premiums affordable.

Ms. CASTOR. OK.

Can these high-value networks improve care coordination and move us towards a system where we pay for quality rather than quantity in our healthcare system?

Mr. PRATT. Absolutely. Our members are working very hard toward that end.

Ms. CASTOR. See, I think this network adequacy in the marketplace is an important issue. We need to make sure that consumers have access to providers in their area and that they have enough choices to get the care they need when they need it.

Republicans should not attack the ACA for letting the private market work. And, remember, personal responsibility is fundamental; it's a fundamental tenet of the Affordable Care Act. And it's oftentimes the customer's responsibility to review all of the choices they have, whether it's bronze, silver, gold, platinum, and the networks contained therein, and make their own choice.

So the law sets key new standards and provides important protections, but insurers and providers will continue to negotiate to ensure sufficient access at fair prices.

Thank you very much. I yield back.

Mr. BURGESS [presiding]. The gentlelady yields back.

The chair recognizes the gentleman from Ohio, Mr. Johnson, 5 minutes for your questions, please.

Mr. JOHNSON. Thank you, Mr. Chairman.

Wow. So much to talk about, so little time to talk about it all.

Gentlemen, thank you for joining us today.

You know, one of the reasons this committee has requested this information from you is because the administration has refused repeatedly to provide any data on who is actually paying for the Affordable Care Act. In fact, one White House spokesman told reporters to ask your industry for this information.

So here's the question for you: Do you currently provide any information to the administration on who has paid for their plan? If yes, what information do you provide and how is it provided and how often? Do you provide any information to the administration?

Mr. WINGLE. The only information we provide around payment is related to the invoicing we do with the government to get the premium tax credit.

Mr. JOHNSON. And how is it provided and how often?

Mr. WINGLE. It's the process we described earlier. It's a workaround process because the financial management module is not fully constructed on the FFM, and it's done monthly.

Mr. JOHNSON. And who did you send it to, Mr. Wingle?

Mr. WINGLE. Send it to CMS.

Mr. JOHNSON. OK.

Well, it's a little confusing. So the administration will pay your industry a subsidy for potential customers who never even effectuate their enrollment. So if you're not providing the details to the administration on who's paying for the Affordable Care Act, how are they paying you? What are they basing their payments to you on?

Mr. WINGLE. I'd only make one clarification. We do not submit information for payment from the government for members who are not effectuated, who haven't made their own portion of the binder payment. We do not do that.

Mr. JOHNSON. Well, let me dig a little deeper then. So how do you get paid? How do you get paid, and what is that based on? What information do you provide the government, the administration, that gets you paid?

Mr. WINGLE. The process essentially works because we have the enrollment file information. We understand the premium for the plan selected by the consumer on that enrollment file.

Mr. JOHNSON. So you're paid based on enrollment, not on actual payment?

Mr. WINGLE. We understand the member's responsibility on that enrollment, and the difference between the premium rate and the member responsibility tells us what the government is. And we roll that figure up monthly.

Mr. JOHNSON. So if you only submit for effectuated—I can't even pronounce that word—doesn't the administration know the pay rate? Don't they know how much these people are paying?

Mr. MATHEIS. Yes, sir, they've determined the subsidy eligibility as part of the enrollment process.

And so a file would come to us; we'd bill for the member responsibility. Upon collection of that member responsibility, then we would typically, if the system were working as designed, we would send a file to the government, to the exchange, saying, here are the members that have effectuated enrollment and here's ultimately the payment that is back due to us.

Mr. JOHNSON. OK.

So do you believe the administration is currently able to report the payment rate or who is fully enrolled? Do you think they have that information, based on what you give them?

Mr. MATHEIS. So, to date, the payments that are coming back and forth are estimated. So there's not been a direct reconciliation between our company and the exchange on a member-by-member basis. That's one of the works in progress that we discussed on the back-end discussion we had earlier in the day, sir.

Mr. JOHNSON. Considering, then, that the administration is able to report who selects a plan on HealthCare.gov, would it would be possible for them to gather information on who has actually paid for a plan?

Let's start down with Mr. Pratt.

Mr. PRATT. Representative, it's my understanding that that capability is not present yet. I'm not sure——

Mr. JOHNSON. Mr. Coyne?

Mr. PRATT. [continuing]. Whether it may be in the future.

Mr. JOHNSON. OK.

Mr. COYNE. Yes, it's my understanding, as well, that that capability isn't ready yet.

Mr. JOHNSON. Mr. Wingle?

Mr. WINGLE. I don't know what the administration can infer from the data they have, but I know the financial management module itself is not available.

Mr. JOHNSON. Mr. Evanko?

Mr. EVANKO. One bit of color I'll add to my colleagues is the submission for APTC is only for those that are APTC-eligible. So there's also people that do not qualify for that that should be in that calculation.

Mr. JOHNSON. OK.

Mr. Rodgers?

Mr. RODGERS. Yes, I think my colleagues are correct in their statements, and we're still working on the reconciliation process for payment.

Mr. JOHNSON. OK.

Mr. Matheis?

Mr. MATHEIS. I would concur with the other statements.

Mr. JOHNSON. OK.

Final question: Does the administration know who's paid for their plan?

Mr. Pratt?

Mr. PRATT. Congressman, I don't know the answer to that question.

Mr. JOHNSON. Mr. Coyne?

Mr. COYNE. I don't know either.

Mr. WINGLE. I don't know what the administration knows about the enrollment in terms of who's paid.

Mr. EVANKO. I don't know either.

Mr. RODGERS. No, sir.

Mr. MATHEIS. No, sir.

Mr. JOHNSON. It's interesting that they sent us to ask you folks.

OK. Mr. Chairman, I yield back.

Mr. BURGESS. The gentleman yields back his time.

The chair recognizes the gentleman from Kentucky, Mr. Yarmuth, 5 minutes for your questions, please.

Mr. YARMUTH. Thank you very much, Mr. Chairman.

And I'm really glad we had this hearing. That's something I usually don't say very often, but this has been a very illuminating hearing, because I think what it's done, very clearly, is to show what our colleagues on the other side's strategy is, which is to try and hold a hearing in which they can grab a headline that will in some way scare the American people about the Affordable Care Act rather than providing true information about what's going on.

And it's clear from the desperation, once their initial strategy of trying to deal with this alleged failure to pay premiums, now they've moved on to try and scare people about what premiums might increase by later, either next year or in the future.

So, and I'm glad you all stressed how important it was that you not give up your competitive position, because obviously you're all competing in the markets.

And I could turn that strategy around and do the same thing and ask you speculative questions like, will the premium increases that we are likely to see approach the 38 percent that we were seeing in 2010 before the Affordable Care Act was passed, and ask you to speculate on that, but I won't do that. And I could ask you about what the rate of cancellations of policies were prior to the Affordable Care Act.

And I could also ask you—and I think this would be a fair question; I wouldn't expect you to answer—how many of your insurance companies, because of the success of the Affordable Care Act enrollment so far and the beneficial mix of younger people, has prompted you to explore doing business in other States, as has been reported in the media. And I think that would be a question that I would love to have the answer to.

I know, for instance, in Kentucky, the co-op, the nonprofit Kentucky co-op, which is competing in the exchange, is now getting ready to do business in West Virginia, because they don't have a co-op and they see an opportunity there. And I think the Maine co-op is planning to do business in—or, I'm sorry, the Massachusetts co-op in Maine, because they see an opportunity there.

So I think all these things are indications that the Affordable Care Act, far from being the train wreck which many have suggested it would become, is actually getting a great deal of traction as it speeds down the tracks.

And just to put it in perspective, in Kentucky, we have insured in the period of 6 months roughly half of the previously uninsured population of the State. We have—411,000 people now have coverage in Kentucky under the ACA. Three-quarters of those—in answer to one of the questions that was asked earlier, three-quarters of those we know previously had no insurance. And 52 percent of all that 411,000 people are under 35.

So we know things are working in Kentucky. And, as Ms. Castor mentioned, things are surprisingly successful in Florida, despite an administration there which has done everything it could to sabotage the Affordable Care Act.

So, we can speculate about and argue about the level of success, whether it's a success or a train wreck, but the markets certainly

have had something to say about how they view the Affordable Care Act in terms of your businesses. I look at those share prices of the companies represented here and one based in my own State. Humana is based in my district. When the Affordable Care Act was enacted, their stock price was 44; now it's 110. Aetna's was 33; now it's 72. UnitedHealthcare was 27; now it's 75. And Cigna's was 34, and now it's 83, roughly.

So the market has made a judgment, I think, about the fact that, at least in terms of your business, the Affordable Care Act has offered a significant financial benefit.

So I think, again, one of the things that's fascinating about this hearing is we know what the Republicans have tried to do, and that's to scare the American people and to use every little indication of a problem to reflect some kind of a doomsday scenario that we are looking at.

And, fortunately, the facts on the ground, whether it's the marketplace, whether it's the experience in Kentucky or Florida or California, where literally millions of people, by one estimate, 20.8 million people, got coverage under the ACA or bought coverage because of the ACA in the private markets outside the exchanges, we are doing—it's doing exactly what we intended it to do.

We know there have been glitches, we know there have been problems. Any undertaking of this magnitude would experience those. But, again, I thank you for your participation, and I thank you for this hearing.

And I yield back.

Mr. BURGESS. The gentleman yields back.

The gentleman from New Mexico is recognized for 5 minutes, Mr. Lujan, for your questions, please.

Mr. LUJAN. Thank you, Mr. Chairman.

Mr. Matheis, your company's CEO said last week that the surge in enrollment in March included a higher percentage of young people than in earlier months. Isn't that correct?

Mr. MATHEIS. That is correct, sir.

Mr. LUJAN. And, Mr. Evanko, your CEO said something similar last week, as well. Isn't that correct?

Mr. EVANKO. That's correct.

Mr. LUJAN. And, as a general matter, all else being equal, a higher percentage of young people in the risk pool will help lower premiums. Isn't that correct?

Mr. Evanko?

Mr. EVANKO. That's a complicated question. It's an important one, but it's a complicated question.

Mr. LUJAN. I think that all that we've heard and from all the actuaries is that the answer is, yes, we need more young people in. It lowers premiums.

Mr. Pratt, insurance company premiums are market-sensitive information that companies are not eager to let their competitors know until the last minute. Isn't that correct?

Mr. PRATT. Representative, it is competitively sensitive information. I don't know that I could speak to their particular perspective on that question.

Mr. LUJAN. Well, it seems like they'd want to keep it to themselves as long as they're able to so that competitors aren't able to

get their hands on it and adjust accordingly. Is that correct? Is that fair?

Mr. PRATT. It's fair to say it's competitively sensitive information.

Mr. LUJAN. And is it correct that many insurance commissioners around the country have the authority to review rates and that the final rates consumers pay are sometimes lower than the rates that are actually filed?

Mr. PRATT. Yes, Representative. Typically speaking, rates are filed with the States, and the States review those rates.

Mr. LUJAN. Very good. I used to sit on a regulatory body that the superintendent of insurance was under our jurisdiction, so I appreciate the answer to that. Because I know what we saw when I was there, as well, sir, so I'd certainly agree that.

Is it also true that the ACA contains a series of policies—reinsurance, risk adjustment, and risk corridors—to help mitigate potential premium increases?

Mr. PRATT. Congressman, one goal of the 3Rs program, the so-called 3Rs program, is to stabilize premiums in the early years of implementation.

Mr. LUJAN. And a final question to the panel is: Before the ACA, wasn't it common for insurance premiums to increase significantly year to year, often by double digits?

Anyone?

Is there anyone that would disagree that premiums increased by more than 50 percent between 2003 and 2010?

Hearing none, I guess the answer to that is that there's agreement.

The 8 million figure only includes people who have signed up for insurance directly through the Federal and State marketplaces that my colleagues are trying to dismiss, but people can also sign up for private ACA-compliant plans outside of the marketplaces. We don't have a lot of conversation about that.

Mr. Pratt, are individuals able to enroll in some of the plans that AHIP represents outside of the Federal and State marketplaces?

Mr. PRATT. That's correct.

Mr. LUJAN. The CBO estimates that 5 million people will purchase ACA-compliant plans outside of the marketplace this year. These individuals will obtain the same protections and be a part of the same risk pools in each State as those who enrolled via the marketplaces.

Mr. Rodgers, how many of HSCS's enrollments have been outside of the marketplace?

Mr. RODGERS. As I said in my opening testimony and was provided in written form to the committee, I believe we had about 230,000 off-exchange applications during the open enrollment period ending April 15.

Mr. LUJAN. And about how many applicants have you received overall?

Mr. RODGERS. We've received, overall, about 830,000 applications across our five States.

Mr. LUJAN. So that sounds like it's representing about 1.2 million culvert lives. So about 28 percent of your enrollees signed up outside of the marketplaces; that's a significant number. And I understand that payment data is not complete but in the earlier months

of this year, what percentage of individuals enrolling in plans outside of the marketplace have paid?

Mr. RODGERS. In my written comments to the committee, I shared with you the on-exchange and off-exchange payment rates because there is some difference. Typically, the payment completion rates are a little bit higher off exchange versus on exchange, and you should have that data.

Mr. LUJAN. So from what I was able to get from your testimony was that between January and April, 90 to 93 percent; and in May, 63 percent today, and we can verify that in there. Does that sound accurate, though?

Mr. RODGERS. That's correct. That's in my written comments.

Mr. LUJAN. Can any of our other witnesses provide us with information on how many off-exchange enrollments they have had to date? If not—Mr. Evanko.

Mr. EVANKO. We have approximately 40,000 off-exchange ACA enrollments. That's about one-third of our total ACA compliant book.

Mr. LUJAN. And what I'd like to do is ask our witnesses if they'd be willing to provide the committee with detailed information on their off-exchange enrollments. Would that be OK with everyone?

Mr. RODGERS. Yes.

Mr. LUJAN. Very good. I appreciate that.

You know, later on today we're going to having some other hearings in other areas, despite the demonization and demagoguing of the Affordable Care Act, over 8 million enrollees, can you imagine what it would have been if Democrats and Republicans would have worked together to fix issues that needed fixing but we were able to get more people covered? Who knows where that number would have been.

But later on today, we're going to be having a hearing on taking away someone's Fifth Amendment rights. We have my colleagues that are still refusing to release 39 interview transcripts at an IRS hearing. There are going to be other hearings. Another request on a hearing with Benghazi, even though there's been seven other hearings, 50 repeal attempts on the Affordable Care Act.

I think there's a lot of important pressing business that we as the Congress need to get our hands around. And I am certainly hopeful that in the history and tradition of this committee, with all that I've learned from our senior members, there once upon a time was an effort for us to work together and get along, and I certainly hope that those days return. Every time I'm home, that's what we hear.

So all the witnesses that are here today, thank you so much; chairman, again, for you being here, as well, and the hearing being brought together today, an important conversation I hope that we're able to bring more facts into the debate. Thank you very much.

Mr. BURGESS [presiding]. Gentleman's time is expired.

The chair recognizes Ranking Member DeGette for follow-up.

Ms. DEGETTE. Mr. Chairman, I just wanted to follow up on Mr. Lujan's questioning with the off-exchange enrollments, because as we've learned, there have been a number of off-exchange enroll-

ments in addition to the enrollments in the ACA, both in the Federal exchange and the State exchanges.

So I would ask unanimous consent; the committee has made a request of 160 plans, including plans from this panel here, that they provide information about enrollment figures and premium payments for those plans that are under the Affordable Care Act exchanges. I would ask also if we would ask those same plans for that same information on the off-exchange enrollments.

Similar to the data that we got from Blue Cross and Blue Shield, it would be helpful to know how many off-exchange enrollments we have had from these 160 plans and what the premium payments have been, so I'd ask unanimous consent that we also ask for that information.

Mr. BURGESS. Without objection. The gentlelady yields back.

I recognize myself for follow-up. And I would just say on the off enrollment, I'm one of those members. I actually had both Blue Cross and Blue Shield and HealthCare.Gov on hold, or they had me on hold on December 23 and December 24, and it was kind of a race to see who would have a live person answer the phone first. And I think, if I recall correctly, Blue Cross went off that day, so I was probably an off-exchange enrollment, so you may count me as that.

I would just like to ask each of you in follow-up, many of the products you're offering are only affordable because the government subsidizes part of the premium cost. Do you know what percentage of the plans with paid premiums and effectuated enrollment received some form of subsidy from the taxpayer? Mr. Coyne, I'll start with you and we'll just go down the line.

Mr. COYNE. We don't have that information at this point.

Mr. BURGESS. Would you provide it for the record?

Mr. COYNE. Yes, we'd be happy to when we get it.

Mr. BURGESS. Mr. Wingle.

Mr. WINGLE. Our experience probably comports with generally-available published information on that. It's a majority of our membership.

Mr. BURGESS. And again, can I ask you to submit that for the record?

Mr. Evanko.

Mr. EVANKO. For our on-exchange customers, 80 to 85 percent are eligible to APTC.

Mr. BURGESS. Mr. Rodgers.

Mr. RODGERS. Yes, I believe we submitted that information, if I understood your question, in the two submissions for April; and with the May 20 submission, we'll provide something similar.

Mr. WINGLE. As did we.

Mr. BURGESS. Mr. Matheis.

Mr. MATHEIS. Yes. As you know, that number is a moving target, but it is around 79 percent for us.

Mr. BURGESS. And would you do your best to give us an accurate representation for the record.

What about a situation where an individual enrolls but then cancels their plan? Are you only to pay the subsidy monthly or would you be responsible for returning a portion of the subsidy throughout the year? Mr. Coyne, let's start with you.

Mr. COYNE. We don't have that information.
Mr. BURGESS. And will you submit that for the record?
Mr. COYNE. Yes.
Mr. BURGESS. Will you try to find that for us?
Mr. Wingle.
Mr. WINGLE. Could you repeat the question, please, Mr. Chairman.
Mr. BURGESS. A situation where an individual enrolls but then cancels their plan. Are you only paid the subsidy monthly, or would you be responsible for returning the portion throughout the year?
Mr. WINGLE. Returning the portion of premium paid or——
Mr. BURGESS. The advanced premium tax credit.
Mr. WINGLE. The subsidy. The subsidy, under the 3-month grace period rules, we retain until cancellation.
Mr. BURGESS. So you would not be required to return that?
Mr. WINGLE. No, not until a member has canceled.
Mr. BURGESS. If the member just simply doesn't pay, they make their first payment, maybe their second payment and then they stop. At the end of that 3-month grace period, do you have to return the money for those months where the patient didn't pay?
Mr. WINGLE. In compliance with the 3-month grace period rules, we retain any premium tax credit received during the period to help us cover any claims experience we had during the time the member was enrolled.
Mr. BURGESS. So you retain the advanced premium tax?
Mr. WINGLE. According with the design of the rules, yes.
Mr. BURGESS. Mr. Evanko.
Mr. EVANKO. Well, at the end of the 90-day grace period, if the individual has not paid any more premiums, then we owe that money back to CMS and we credit that in the next month's reconciliation process.
Mr. BURGESS. Interesting.
Mr. Rodgers.
Mr. RODGERS. I'm not familiar with that particular aspect of the grace-period payments in terms of the return or not, but I believe that we're only entitled to the money that's for the time the policy is in effect.
Mr. BURGESS. And Mr. Matheis.
Mr. MATHEIS. That's my understanding, as well, sir.
Mr. BURGESS. Mr. Coyne, do you know how much your company has been paid in advance premium tax credits?
Mr. COYNE. Blue Cross and Blue Shield Association does not actually sponsor any of the products that are on the exchanges; our member plans do. So we wouldn't be paid premiums or APTC.
Mr. BURGESS. Mr. Evanko.
Mr. EVANKO. We received four payments so far for the months of January through April, and it's in the range of $30- to $40 million.
Mr. BURGESS. Mr. Wingle.
Mr. WINGLE. We obviously have that data, we can supply the committee with that data.
Mr. BURGESS. And I do need for you to submit that for the record.
Mr. Rodgers.

Mr. RODGERS. We've received some payments. I don't know the value of the payments to date.

Mr. BURGESS. And will you find that information and submit for the record, please.

Mr. RODGERS. Certainly.

Mr. BURGESS. Mr. Matheis.

Mr. MATHEIS. Yes. I don't have that number ready today, but we'd be happy to get it for you.

Mr. BURGESS. The metal plans, you're all familiar with them. I keep hearing about a copper plan that's going to be offered. Are you any of you familiar with that? Are you going to be offering copper plans, Mr. Coyne?

Mr. COYNE. I'm not familiar with that at this point.

Mr. BURGESS. Mr. Wingle.

Mr. WINGLE. Under the current rules for central health benefits and the rules for qualified health plans, we're not currently authorized to offer anything at the so-called copper level. Our plan benefits start at bronze unless somebody qualifies for catastrophic care, and that's of the lowest actuarial value we're allowed to offer presently.

Mr. BURGESS. Mr. Evanko.

Mr. EVANKO. In the event that copper plans were introduced as something that's allowed, we would certainly consider it. Cigna believes in choice as one of our core principles for our customers.

Mr. BURGESS. Thank you.

Mr. Rodgers.

Mr. RODGERS. Currently we're not approved to offer the copper plans. That's certainly something that we believe, that members need more cost-effective programs. I expect that we would offer those.

Mr. BURGESS. Mr. Matheis.

Mr. MATHEIS. My comments would be similar to my colleagues, sir.

Mr. BURGESS. Let me just ask each of you, what is your payment rate for products in the large-group market? Starting with you, Mr. Coyne, what are your payments for products of large-group market?

Mr. COYNE. Individual group plans have that information rather than the association.

Mr. BURGESS. I see.

Mr. Wingle.

Mr. WINGLE. I carry no responsibility for large group. I'd have to get back to you on that.

Mr. BURGESS. Mr. Evanko.

Mr. EVANKO. I am not familiar with the large-group payment rates either. I'm sorry.

Mr. BURGESS. Your company, though, is, I mean, you're in the large-group market.

Mr. EVANKO. We are, sir, yes.

Mr. BURGESS. Will you get that information for us?

Mr. EVANKO. Sure.

Mr. BURGESS. Thank you.

Mr. Rodgers.

Mr. RODGERS. I don't have that information with me.

Mr. BURGESS. But you will provide it for the committee?

Mr. RODGERS. Certainly.

Mr. BURGESS. Mr. Matheis.

Mr. MATHEIS. I'm not sure I understand the question. Could you clarify it for me, please.

Mr. BURGESS. Well, the question was, what are your payment rates for products in the large-group market?

Mr. MATHEIS. So is that what our average premium is or?

Mr. BURGESS. How many people pay?

Mr. MATHEIS. Sorry, sir, I'm still not following the question.

Mr. BURGESS. Well, what we've generally been talking about today is how many people, what percentage of people have paid. So following along that——

Mr. MATHEIS. I'm sorry. I was a little slow in the uptake there. Typically, we would experience somewhere around a 98- to 97-percent premium payment in the large-group market.

Mr. BURGESS. Very well. Thank you all for your attendance today. I ask unanimous consent that members' written opening statements be introduced into the record. Without objection, the documents will be entered into the record.

In conclusion, I'd like to thank all the witnesses and the members who participated in today's hearing. I'd like to thank everyone who stuck with us in until the end, and that would be the witnesses. I remind members they have 10 business days to submit questions for the record, and I ask the witnesses to all agree to respond promptly to the questions. The committee now is stands in adjournment.

[Whereupon, at 12:28 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MARSHA BLACKBURN

- Mr. Chairman, thank you for holding this hearing so that we might have some clarity about the Obamacare Enrollment numbers.
- The rollout of HealthCare.gov was abysmal. In addition, the administration has unilaterally issued numerous delays. I believe that we are not finished with very unpleasant surprises with this law. The American people deserve answers to many questions and we intend to get those answers.
- In March of this year, Secretary Sebelius told us that she could not tell us how many people who had enrolled in plans had actually paid their first month premiums. She was asked if she had asked for that information from insurers, she admitted that she had not.
- The former director of the Center for Consumer Information and Insurance Oversight at CMS, Gary Cohen also said that he did not know.
- I don't know, but I think when you have a name like "oversight" you should have an idea about what is going on.
- Since the Administration was unable, or unwilling to provide the information to Congress, we requested this information from the insurers that the administration lists at participants in the Federally Facilitated Exchanges.
- As we continue to work to I am looking forward to hearing from each of the witnesses today as we continue to shine a very bright light on Obamacare.

Annals of Internal Medicine | ORIGINAL RESEARCH

Changes in Mortality After Massachusetts Health Care Reform

A Quasi-experimental Study

Benjamin D. Sommers, MD, PhD; Sharon K. Long, PhD; and Katherine Baicker, PhD

Background: The Massachusetts 2006 health care reform has been called a model for the Affordable Care Act. The law attained near-universal insurance coverage and increased access to care. Its effect on population health is less clear.

Objective: To determine whether the Massachusetts reform was associated with changes in all-cause mortality and mortality from causes amenable to health care.

Design: Comparison of mortality rates before and after reform in Massachusetts versus a control group with similar demographics and economic conditions.

Setting: Changes in mortality rates for adults in Massachusetts counties from 2001 to 2005 (prereform) and 2007 to 2010 (postreform) were compared with changes in a propensity score–defined control group of counties in other states.

Participants: Adults aged 20 to 64 years in Massachusetts and control group counties.

Measurements: Annual county-level all-cause mortality in age-, sex-, and race-specific cells (n = 146 825) from the Centers for Disease Control and Prevention's Compressed Mortality File. Secondary outcomes were deaths from causes amenable to health care, insurance coverage, access to care, and self-reported health.

Results: Reform in Massachusetts was associated with a significant decrease in all-cause mortality compared with the control group (−2.9%; P = 0.003, or an absolute decrease of 8.2 deaths per 100 000 adults). Deaths from causes amenable to health care also significantly decreased (−4.5%; P < 0.001). Changes were larger in counties with lower household incomes and higher prereform uninsured rates. Secondary analyses showed significant gains in coverage, access to care, and self-reported health. The number needed to treat was approximately 830 adults gaining health insurance to prevent 1 death per year.

Limitations: Nonrandomized design subject to unmeasured confounders. Massachusetts results may not generalize to other states.

Conclusion: Health reform in Massachusetts was associated with significant reductions in all-cause mortality and deaths from causes amenable to health care.

Primary Funding Source: None.

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For author affiliations, see end of text.

Massachusetts passed comprehensive health care reform in 2006 with the goal of near-universal coverage. The law—which expanded Medicaid, offered subsidized private insurance, and created an individual mandate—was a model for the Affordable Care Act (1). Thus, understanding the effects of the Massachusetts law has important policy implications.

Previous research documents that the Massachusetts reform succeeded in expanding health insurance among adults aged 19 to 64 years by 3 to 8 percentage points (1–5). Studies also indicate improvements in access to care (6–8), self-reported physical and mental health (9), use of preventive services (2, 10), and functional status (1, 11). However, there has been no evidence on the law's effect on mortality. Previous research on the effect of health insurance on mortality is mixed. Some observational studies suggest as much as a 40% increased risk for death for uninsured versus insured adults (12, 13), and an analysis of Medicaid expansion to low-income adults detected a 6% decrease in statewide mortality (14). Other studies, including 2 randomized trials of insurance expansion, found little or no effect on mortality (15–17).

Our study's objective was to examine the changes in mortality associated with the Massachusetts reform. We hypothesized that the reform reduced mortality, particularly from causes potentially treatable with timely care (such as cardiovascular disease, infections, and cancer), and that larger changes occurred among groups likely to benefit from the law—previously uninsured adults and those with higher prereform mortality rates.

METHODS

Study Design

Our study used a quasi-experimental pre–post design with a control group and compared average mortality in Massachusetts before and after reform to mortality changes over the same period for similar populations in states without reforms (also known as a "differences-in-differences" analysis [18]). Our preferred specification used propensity score methods to create a control group of counties in nonreform states that best matched the distribution of prereform characteristics in Massachusetts counties (19, 20).

The Massachusetts law had several components: Medicaid expansion starting in July 2006, subsidized private plans for adults with incomes less than 100% of the federal poverty level in October 2006, and expanded coverage subsidies for adults with incomes up to 300% of the federal

See also:
Editorial comment 649
Web-Only
Supplement

Context

After passage of a 2006 law that expanded health insurance coverage, studies have found many changes in health and health care, but none has reported changes in mortality.

Contribution

This study found that when Massachusetts counties were compared with similar counties in other states, all-cause and health care–amenable mortality decreased after Massachusetts passed the law.

Caution

The study design cannot rule out the effects of unidentified confounders and thus cannot establish cause and effect.

Implication

The association between more insurance coverage and fewer deaths reported here is consistent with other evidence that expanding insurance coverage can improve health.

—The Editors

poverty level in January 2007. It included an individual mandate effective for the 2007 tax year and "minimum creditable coverage" insurance standards (21). We defined the postreform period as 2007 to 2010, with 2006 omitted as a transitional year (although we included 2006 in sensitivity analyses). The prereform period was 2001 to 2005.

Data

Our data came primarily from the Centers for Disease Control and Prevention's Compressed Mortality File, which provides county-specific annual mortality rates stratified by age, sex, and race (22). For confidentiality, the publicly available data set suppresses death counts for cells with fewer than 10 deaths. We obtained access to the nonsuppressed data set under agreement with the Centers for Disease Control and Prevention. Our sample was adults aged 20 to 64 years, the reform's primary target group (with 19-year-olds excluded because persons aged 15 to 19 years are grouped together in the data set). In addition to age, sex, and race, our estimates were adjusted for year-specific county-level poverty rates, median income, unemployment, and the percentage of Latino persons in the population (all from the Area Resource File [ARF] [23]). Subgroup analyses used prereform county-level uninsured rates from the U.S. Census Bureau's 2005 Small Area Health Insurance Estimates (24).

We also analyzed measures of coverage, health care access, and self-reported health status from 2 nationally representative household surveys: the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) and the Census Bureau's Current Population Survey (CPS). These data sets have been used previously to examine the effect of the Massachusetts reform on coverage and access (2–4, 8, 9, 25). We present independent estimates using methods analogous to our mortality analysis to provide additional context for our results. For these data sources, we were able to include 19-year-olds, so the sample contains all adults aged 19 to 64 years.

This project used preexisting deidentified data and was deemed exempt from review by the Harvard Institutional Review Board. The project received no external funding.

Outcome Measures

Our primary outcome was all-cause mortality. Our secondary outcome was mortality amenable to health care, adapted from previous research (26–29), to focus on deaths related to conditions that are more likely to be preventable or treatable with timely care, including heart disease, stroke, cancer, infections, and other conditions (30). **Table 1** of the **Supplement** (available at www.annals.org) lists the diagnosis codes from the International Classification of Diseases, 10th Revision, used in this definition and a more restrictive alternate definition tested in a sensitivity analysis.

Additional outcomes were health insurance from the CPS and self-reported health (excellent or very good vs. good, fair, or poor) and access-to-care measures (cost-related delays in care, lack of a usual source of care, and absence of a preventive visit in the past year) from the BRFSS.

Statistical Analysis

Annual county-level death counts based on age, sex, and race were the unit of observation for the mortality analysis. **Table 1** describes the analytic sample, which contains information on the number of counties; states; age-, sex-, and race-specific county-level cells; and population per year.

Our regression models estimated the average annual pre–post change in mortality for age-, sex-, and race-specific cells in Massachusetts counties relative to comparison counties in nonreform states (31). The study contained 5 years of prereform data (2001 to 2005) and 4 years of postreform data (2007 to 2010). Given that our outcome variable is number of deaths in each cell, our multivariate regression analyses fitted a generalized linear model using a negative binomial distribution and log link, with cell population as the exposure variable. We adjusted our analyses for race, sex, age, state, year, and economic factors (unemployment rate, poverty rate, and median income) specific to the county year (**Supplement**).

Robust SEs were clustered at the state level to account for serial autocorrelation and for the state-level nature of the policy intervention (18), which is standard in population-based policy analyses (14, 32–37). Sensitivity analyses included the pooling of annual data into prereform and postreform periods to remove potential autocor-

relation, an interrupted time series model, adding 2006 (the implementation year) to our postreform data, and county-level clustering of SEs. We also tested a linear model using death rate per 100 000 adults as the outcome to provide simple estimates of absolute change and results similar to prior research (14). Cells were weighted by population size to yield representative estimates.

Secondary analyses used individual-level information from the BRFSS and CPS on coverage, access, and health status and were adjusted for age, sex, race/ethnicity, employment, household income, year, and state. For these binary outcomes, we used a generalized linear model with a logit link and predicted probabilities to describe the magnitude of absolute changes (38).

Selection of Control Group

For the mortality analysis, we used propensity scores to define a control group of counties in nonreform states that were most similar to prereform Massachusetts counties. We estimated propensity scores with a population-weighted logistic regression model using age distribution, sex, race/ethnicity, poverty rate, median income, unemployment, uninsured rate, and baseline annual mortality as predictors (**Table 2** of the **Supplement**). The quartile of counties with the highest propensity scores, indicating the closest match to the overall population of Massachusetts' 14 counties, was used as the control group in the mortality analysis. This approach yielded excellent balance on key features between Massachusetts and our control group (**Table 2**) and provided adequate sample sizes for subgroup analyses. We also tested a more traditional propensity score–regression adjustment method and a 2:1 nearest-neighbor propensity score–matching approach, which yielded similar overall results (**Supplement**).

Table 1. **Analytic Sample**

Variable	Value, *n*
Counties	
Massachusetts	14
Control group	513
United States (non-Massachusetts)	3127
States (including District of Columbia)	
Massachusetts	1
Control group	46
United States (non-Massachusetts)	50
Age-, sex-, and race-specific county-level cells	
Massachusetts	3985
Control group	142 840
United States (non-Massachusetts)	836 413
Average population during study period (persons aged 20 to 64 y)	
Massachusetts	3 900 000
Control group	44 300 000
United States (non-Massachusetts)	173 400 000

Identifying a control group with similar mortality trends in counties not in Massachusetts is the key to our approach (20). We tested for differences in the prereform mortality trends for 2001 to 2006 between Massachusetts and the control group using linear and quadratic time trends interacted with an indicator variable for Massachusetts. We repeated this test for the entire U.S. population.

For the analysis of coverage, access, and self-reported health in the CPS and BRFSS, we compared Massachusetts with the other New England states (Maine, Vermont, New Hampshire, Rhode Island, and Connecticut) before and after reform. These data sets do not contain the county-

Table 2. **Summary Statistics for Study Sample Before Reform**

County-Level Characteristic	Massachusetts, %*	Control Group, %*	*P* Value for Massachusetts vs. Control Group	Rest of United States, %*	*P* Value for Massachusetts vs. Rest of United States
Covariates					
Age					
20–34 y	33.2	33.1	0.95	34.5	0.46
35–44 y	26.3	25.9	0.51	25.3	0.090
45–54 y	24.0	24.3	0.69	23.7	0.68
55–64 y	16.5	16.7	0.79	16.4	0.95
Male	48.9	49.1	0.13	49.6	<0.001
White race	87.4	85.0	0.28	81.0	0.003
Black race	7.0	9.0	0.26	12.8	<0.001
Other race	5.6	6.0	0.62	6.2	0.46
Latino ethnicity	7.6	7.9	0.86	14.0	<0.001
Poverty rate	9.6	10.2	0.55	12.7	0.002
Median household income, $†	62 271	59 124	0.30	52 481	0.001
Unemployment rate	5.0	5.1	0.62	5.4	0.058
Uninsured rate	13.6	14.5	0.18	19.8	<0.001
Outcomes					
All-cause mortality (deaths per 100 000)	283	297	0.26	341	<0.001
Health care–amenable mortality (deaths per 100 000)	185	197	0.11	221	<0.001

* Data are percentages, except for median household incomes and outcomes.
† Median income was inflation-adjusted to 2010 U.S. dollars.

level detail needed for our propensity score method, so we followed previous research in using this control group (2, 3, 11).

Subgroup Analysis

We did prespecified subgroup analyses to test for heterogeneous mortality changes and their effect on disparities. We compared adults aged 20 to 34 years with those aged 35 to 64 years, non-Latino white adults with nonwhite and Latino adults, residents of low-income counties with residents of high-income counties (based on median household income in Massachusetts), and residents of counties with low rates of uninsured adults with those with high rates of uninsured adults (based on median county uninsured rates in Massachusetts before reform). In each analysis, we specified an interaction term between Massachusetts reform and the variable in question to test for significantly different effects across subgroups.

Finally, in a sensitivity analysis, we used elderly adults (aged ≥65 years) as an additional control group. This approach subtracts any secular trend for elderly adults in Massachusetts from the estimated mortality change for nonelderly adults (**Supplement**). Netting out the mortality changes in this group is a conservative approach. Although the Massachusetts reform did not directly affect coverage for most elderly adults, it did expand insurance to the few who did not meet the lifetime earnings requirement for Medicare (2, 39). Thus, it may have had some effect on health in this age group, but one would expect such effects to be much weaker than those on the targeted population of nonelderly adults.

Role of the Funding Source

This study received no funding.

RESULTS

Sample

Table 2 presents descriptive statistics and baseline mortality for counties in Massachusetts, our control group, and all U.S. counties outside Massachusetts. Massachusetts had significantly fewer minorities, more women, lower poverty and uninsured rates, and lower baseline mortality than the rest of the United States. However, there were no statistically significant differences for these outcomes between Massachusetts and the control group, indicating excellent balance from the propensity score approach.

Examination of prereform mortality trends further supports the use of the control group (**Table 3** of the **Supplement**). We found no evidence of divergence between Massachusetts and the control group in linear or quadratic models ($P = 0.120$ and 0.116, respectively). In contrast, the mortality trend in Massachusetts diverged from the rest of the United States before 2006 ($P < 0.001$).

Changes in Mortality

The **Figure** shows the unadjusted annual mortality rates for nonelderly adults in Massachusetts and the control group from 2001 to 2010. All-cause mortality in the 2 groups followed a similar pattern until implementation of the reform in 2006 to 2007, after which mortality in Massachusetts began to decrease relative to the control group. Health care–amenable mortality followed a similar pattern, whereas trends for other causes of death showed minimal changes in Massachusetts and the control group.

Table 3 presents regression estimates for changes in mortality associated with the Massachusetts reform. In our primary specification, adjusted all-cause mortality decreased in Massachusetts after reform by 2.9% ($P = 0.003$) compared with the control group. Mortality amenable to health care decreased by 4.5% ($P < 0.001$). An alternate definition of health care–amenable mortality (28) produced a slightly larger relative reduction (−5.5%; $P = 0.002$), and deaths from nonamenable causes showed no significant decrease (−2.0%; $P = 0.26$) (**Supplement**).

Several sensitivity analyses produced similar results, including those using propensity score regression–adjustment or 2:1 matching approaches, clustering of SEs at the county level, or a linear model with the death rate as the outcome (**Table 4** of the **Supplement**). The relative decrease of 2.9% in all-cause mortality, paired with a baseline mortality in Massachusetts of 283 per 100 000 adults, implies an absolute mortality change of −8.2 per 100 000 adults. This reduction is similar to the linear model estimate of −9.3 per 100 000 adults ($P = 0.014$) reported in the **Supplement**.

Mortality Changes Among Subgroups

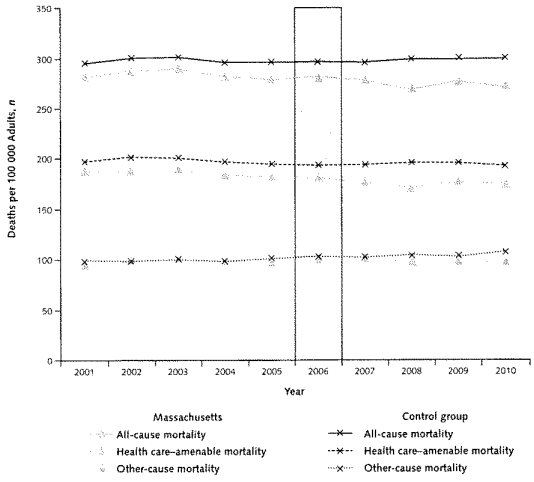
Table 4 presents subgroup analyses. Relative mortality reductions in Massachusetts compared with the control group were significant for white and nonwhite adults, adults aged 20 to 34 and 35 to 64 years, and residents of counties with lower incomes and higher baseline uninsured rates. Although relative mortality changes were larger for Latino and nonwhite adults (−4.6%; $P < 0.001$) than white adults (−2.4%; $P = 0.001$), the between-group difference in these estimates was not significant ($P = 0.062$).

The **Figure** of the **Supplement** shows unadjusted mortality trends for elderly adults, with no apparent divergence between Massachusetts and the control group before or after reform. A model using elderly adults as an additional within-state control group (**Table 5** of the **Supplement**) showed a 3.3% decrease in all-cause mortality ($P = 0.066$) for nonelderly adults and a 0.1% increase for elderly adults ($P = 0.93$) in Massachusetts after reform. This model also showed a 4.9% decrease in health care–amenable mortality ($P < 0.001$) for nonelderly adults and a 0.2% increase for elderly adults ($P = 0.90$).

Coverage, Access to Care, and Health

Table 5 shows changes in coverage, access to care, and self-reported health. Compared with other New England states, reform in Massachusetts was associated with significant reductions in the uninsured rate (change in predicted probability, −6.8 percentage points, a 57% relative de-

Figure. Unadjusted mortality rates for adults aged 20 to 64 years in Massachusetts versus control group (2001–2010).



The shaded band designates the beginning of the Massachusetts state health care reform that was implemented starting in July 2006. "Health care–amenable mortality" is as defined in **Table 1** of the **Supplement** (available at www.annals.org). "Other-cause mortality" contains all other causes of death not included in that definition.

crease from baseline); cost-related delays in care (−2.0 percentage points, a 22% relative decrease); lacking a usual source of care (−1.9 percentage points, a 13% relative decrease); having no preventive visit in the last year (−4.0 percentage points, a 13% relative decrease); and reporting good, fair, or poor health (−1.8 percentage points, a 5% relative decrease) (all changes, $P < 0.001$). Results were nearly identical with linear probability models or without state clustering of SEs (**Table 6** of the **Supplement**).

Estimated Mortality Effect

To assess the plausibility of our estimated decrease in mortality, we compared it with the coverage gains we detected (**Table 7** of the **Supplement**). In absolute terms, we

Table 3. Mortality Before and After Massachusetts Health Care Reform Among Adults Aged 20 to 64 Years (2001–2010)*

Outcome	Unadjusted Mortality per 100 000 Adults		Unadjusted Relative Change		Adjusted Relative Change	
	Prereform	Postreform	Difference (95% CI), %	*P* Value	Difference (95% CI), %	*P* Value
All-cause mortality						
Massachusetts	283	274	−4.2 (−8.0 to −0.4)	0.032	−2.9 (−4.8 to −1.0)	0.003
Control group	297	299				
Health care–amenable mortality						
Massachusetts	185	175	−4.3 (−7.2 to −1.5)	0.003	−4.5 (−6.2 to −2.7)	<0.001
Control group	197	195				

* Relative changes estimated by using negative binomial generalized linear models with log link. Adjusted model controlled for age, sex, race/ethnicity, poverty rate, median income, unemployment rate, and state of residence.

Table 4. Subgroup Analyses of Changes in All-Cause Mortality After Massachusetts Health Care Reform Among Adults Aged 20 to 64 Years (2001–2010)*

Subgroup	Unadjusted Mortality in Massachusetts Before Reform per 100 000 Adults	Adjusted Relative Change, Massachusetts vs. Control Group (95% CI), %	*P* Value		Absolute Change in Predicted Mortality per 100 000 Adults†
			Subgroup	Between-Group Difference	
Full sample	283	−2.9 (−4.8 to −1.0)	0.003	–	−8.2
Race/ethnicity					
Non-Latino white‡	295	−2.4 (−3.8 to −1.0)	0.001	0.062	−7.1
Latino or nonwhite‡	231	−4.6 (−6.3 to −2.8)	<0.001		−10.6
Age					
20–34 y	77	−3.6 (−6.9 to −0.4)	0.030	0.38	−2.8
35–64 y	386	−2.2 (−3.8 to −0.6)	0.008		−8.5
County median income					
Low income	312	−3.0 (−4.6 to −1.3)	<0.001	0.33	−9.4
High income	257	−1.8 (−4.0 to 0.5)	0.120		−4.6
County prereform uninsured rate					
Low uninsured	295	−1.7 (−3.8 to 0.4)	0.118	0.41	−5.0
High uninsured	273	−3.3 (−6.0 to −0.6)	0.015		−9.0

* Relative changes were estimated by using negative binomial generalized linear models with log link. The model was adjusted for age, sex, race/ethnicity, poverty rate, median income, unemployment rate, and state of residence.
† Calculated by using adjusted relative change multiplied by baseline subgroup-specific mortality for Massachusetts.
‡ Although unadjusted mortality was higher for non-Latino white adults than for Latino or nonwhite adults, this is primarily due to the different age distributions of the groups. After adjustment for age by standardization to the age distribution of white adults, baseline mortality for Latino or nonwhite adults was significantly higher (312 per 100 000 adults) than for non-Latino white adults (295 per 100 000 adults). This model omits from the sample any deaths with "unknown" ethnicity because the data set has no corresponding population denominator for that group necessary to calculate a death rate.

found a decrease in mortality of 0.0082 percentage points (8.2 per 100 000 adults) concurrent with an increase in coverage of 6.8 percentage points, which implies that for approximately every 830 adults who gained insurance, there was 1 fewer death per year.

DISCUSSION

The Massachusetts 2006 health care reform was associated with significant reductions in all-cause mortality over 4 years of follow-up relative to a control group of similar counties in states without reform. Reductions were concentrated in causes of death that were more plausibly amenable to health care and in populations most likely to benefit from expanded access, particularly residents of counties with lower incomes and higher prereform uninsured rates.

Compared with the control group, overall mortality in Massachusetts decreased by 2.9%. This relative decrease in mortality is smaller than the 6.1% decrease in mortality associated with several states' Medicaid expansions (14), which is consistent with the fact that Massachusetts began its expansion from a much higher baseline rate of insurance

Table 5. Changes in Coverage, Access to Care, and Self-Reported Health After Massachusetts Health Care Reform Among Adults Aged 19 to 64 Years (2001–2010)*

Outcome	Unadjusted Population Mean in Massachusetts Before Reform, %	Adjusted Odds Ratio After Reform (95% CI)	*P* Value	Absolute Change in Predicted Probability, *percentage points*†
Uninsured (n = 99 661)	11.9	0.43 (0.41–0.45)	<0.001	−6.8
Delayed care due to cost in the past year (n = 215 365)	9.0	0.78 (0.70–0.86)	<0.001	−2.0
No usual source of care (n = 262 761)	14.7	0.84 (0.78–0.89)	<0.001	−1.9
No preventive physician's visit in the past year (n = 166 642)	30.5	0.82 (0.79–0.85)	<0.001	−4.0
Worse self-reported health (n = 214 510)‡	34.7	0.92 (0.88–0.95)	<0.001	−1.8

* All analyses compare pre–post changes in the outcomes for Massachusetts vs. other New England states for the years 2001–2005 and 2007–2010. Data are from the Current Population Survey for the uninsured and the Behavioral Risk Factor and Surveillance System (BRFSS) for the remaining measures. Sample sizes for BRFSS items differ primarily because of changes in the survey year in which each item was queried and small differences in item nonresponse. The model was adjusted for age, sex, race/ethnicity, household income (as a percentage of the federal poverty level), employment status, year, and state of residence.
† Calculated by using change in predicted probability.
‡ Good, fair, or poor vs. excellent or very good self-reported health.

coverage. However, 2 recent experimental studies of insurance have shown neither a mortality benefit of insurance (16, 17) nor statistically significant changes in blood pressure or glycated hemoglobin levels (40), although both found major gains in self-reported health and access to recommended care. The latter studies have the advantages of a randomized design and individual-level data. However, they have much smaller sample sizes (for example, 916 persons gaining coverage in 1 study [17] and roughly 10 000 newly insured in another [40] vs. approximately 270 000 adults gaining coverage in our study) and shorter follow-up (16, 40) than is possible using statewide population data, giving our study far greater statistical power for small absolute changes, such as those detected here.

How does insurance expansion reduce population mortality? Our secondary outcomes trace a plausible causal pathway: Eligibility leads to increased coverage, and such coverage leads to better access and more utilization of clinical services, including office visits, with resulting gains in self-reported health status (a strong predictor of mortality [41, 42]). This potential pathway of coverage leading to health gains through access to clinicians and high-quality care is consistent with Eisenberg and Power's seminal 2000 article (43), which outlines a framework for understanding challenges to improving care for patients in the U.S. health care system.

Our results are consistent with the bulk of previous research on the Massachusetts reform, which demonstrates gains in coverage, access to care, and self-reported health among Massachusetts residents after reform (1, 2, 8, 10, 11). Mortality reductions were concentrated in conditions most likely to be amenable to health care, such as cancer (which can sometimes be prevented with earlier screening or treated more successfully with early detection), infections (treatable with early detection and preventable or less likely to be fatal with better long-term disease management), and cardiovascular disease (treatable in the short term with early detection and partially preventable with risk factor modification). This is consistent with research showing a decline in potentially avoidable hospitalizations after the Massachusetts reform and other insurance expansions (2, 44). Although research on breast cancer did not find a significant effect of the Massachusetts reform (25), our use of a more comprehensive health outcome may have given us greater power to detect changes than analysis of a single diagnosis.

Our number needed to treat was 830 adults gaining insurance to prevent 1 death per year. This estimated coverage-to-mortality effect would be consistent with a 30% relative reduction in individual-level mortality for persons gaining insurance (compared with an estimated 25% relative reduction in mortality from insurance cited by the Institute of Medicine [13] and the 40% relative reduction found by Wilper and colleagues [12]) if overall baseline mortality for these uninsured individuals were 400 per 100 000 adults (**Table 7** of the **Supplement**). This baseline mortality rate would be roughly 1.5 times that of our overall sample, which is consistent with prior research on elevated mortality risks for the uninsured (12, 15). In addition, research suggests that insurance expansion disproportionately enrolls persons in worse health (14, 45) and components of the Massachusetts expansion preferentially targeted adults with disabilities or HIV/AIDS (21). These illustrative calculations assume that mortality reductions occurred only for those obtaining insurance under reform, which may be conservative because the law also expanded benefits (including preventive care and prescription drugs) for many persons who already had insurance.

Reductions in mortality were largest in Massachusetts counties with lower incomes and lower insurance coverage before reform—areas likely to have had the greatest increase in access to care under reform. Mortality reductions were nearly twice as large for minority as for white adults, although this between-group difference was not statistically significant. These results provide useful additional information compared with previous research suggesting that racial/ethnic disparities in coverage and access may not have narrowed after the Massachusetts reform (3, 4).

Our analysis has several limitations. First, we do not have individual-level insurance information and thus cannot directly link mortality changes to persons gaining insurance coverage. Second, defining mortality from causes amenable to health care is somewhat subjective. We built on methods used in prior research (27–29) and tested 2 definitions that provided similar results. Future research distinguishing between treatable and curable conditions would also be worthwhile.

Most important, our quasi-experimental approach cannot definitively demonstrate a causal relationship underlying the association between the Massachusetts reform and the state's declining mortality relative to other states. It is possible that the postreform reduction in mortality in Massachusetts was due to other factors that differentially affected Massachusetts, such as the recession. However, our analysis controlled for several distinct time- and county-specific economic measures. We also found no evidence of a similar decline in mortality among elderly adults in Massachusetts that would suggest a secular trend. Although we cannot rule out unmeasured confounders, it is challenging to identify factors other than health care reform that might have produced this pattern of results: a declining mortality rate in Massachusetts since 2007 not present in similar counties elsewhere in the country, primarily for health care–amenable causes of death in adults aged 20 to 64 years (but not elderly adults), concentrated among poor and uninsured areas and not explained by changes in poverty or unemployment rates.

In conclusion, we find a significant reduction in mortality among nonelderly adults in Massachusetts since its 2006 reform relative to a control group of similar counties in states without such reforms. Although this analysis cannot demonstrate causality, the results offer suggestive evi-

dence that the Affordable Care Act—modeled after the Massachusetts law—may impact not only coverage and access but also mortality. However, it is critical to note the many dimensions in which Massachusetts differs from the rest of the nation, including lower mortality, higher income and baseline insurance coverage rates, fewer minorities, and the most per capita physicians in the country (46). The extent to which our results generalize to the United States as a whole is therefore unclear, which underscores the need to monitor closely the Affordable Care Act's effect on coverage, access, and population health across all states.

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THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

May 5, 2014

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing on "PPACA Enrollment and the Insurance Industry"

On Wednesday, May 7, 2014, at 10:15 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "PPACA Enrollment and the Insurance Industry." This hearing will examine the implementation of the Patient Protection and Affordable Care Act (PPACA), and in particular, the status of enrollment and the marketplace.

I. WITNESSES

The Committee invited representatives from the following insurers: Aetna, Cigna, the Health Care Services Corporation, and Wellpoint. Representatives from America's Health Insurance Plans and the Blue Cross Blue Shield Association also were invited. The witness names will be made available here.[1]

II. BACKGROUND

2014 is the first year of full implementation for the PPACA. Due to the troubled rollout of HealthCare.gov[2] and the numerous delays announced by the administration,[3] a complete assessment of that implementation has been difficult. At the intersection of the individual experience with the health insurance industry and the administration's implementation of the PPACA is the insurance industry.

The first PPACA open enrollment period ended on March 31, 2014, while individuals who were prevented from enrolling because HeatlhCare.gov did not work were given a special exemption period.[4] While the administration periodically has reported on the number of individuals selecting a

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[1] http://energycommerce.house.gov/hearing/ppaca-enrollment-and-insurance-industry.

[2] Sarah Kliff, Philip Rucker and Sandhya Somashekhar, *Sebelius on health-care law rollout: Hold me accountable for the debacle. I'm responsible.* WASHINGTON POST, Oct. 30, 2013. http://www.washingtonpost.com/national/health-science/sebelius-on-health-care-law-rollout-hold-me-accountable-for-the-debacle-im-responsible/2013/10/30/7ef34e04-4197-11e3-a624-41d661b0bb78_story.html.

[3] Elise Viebeck, *HHS widens O-Care penalty exemptions*, THE HILL, May 2, 2014. http://thehill.com/policy/healthcare/205072-hhs-widens-exemptions-from-o-care-penalty.

[4] Robert Pear, *U.S. to Extend Sign Up Period for Insurance*, THE NEW YORK TIMES, March 25, 2104. http://www.nytimes.com/2014/03/26/us/politics/obama-administration-extends-health-enrollment-for-some.html?_r=0.

plan online, they have not provided information on who actually has paid for those plans. The payment rate for plans purchased on HealthCare.gov has remained an ongoing concern because individuals who do not pay their premiums will not become fully enrolled and part of the insurance risk pool.[5] One of the reasons given for why the administration was unable to provide precise enrollment information was because the problematic implementation of HealthCare.gov prevented the building of the systems that would gather that data. A White House spokesman noted that the insurance industry would collect this data, saying "Questions about who exactly has paid for the health insurance can best be directed to those private insurance companies that are collecting those payments."[6] During the problematic rollout of HealthCare.gov, the Committee attempted to obtain more detailed enrollment information from the administration.[7] In light of these comments and the administration's inability to produce detailed information, the Energy and Commerce Committee requested this data[8] from the insurers the administration lists as participants in the Federally-Facilitated Exchange serviced by HealthCare.gov.[9]

Through April 15, 2014, industry data provided to the Committee indicates that the payment rate nationwide is 67 percent. After discussing with industry representatives what would be the appropriate date to obtain a final update of the payment information, the Committee last week requested another submission of the payment rate on May 20, 2014.[10] This week, the administration announced that over 8 million individuals had selected plans via the Federal and State exchanges. They did not provide any data on payment rates.

The insurance industry also will be on the frontline for how consumers and patients experience the PPACA this year. While there may be an effort to control costs, limitations on plan networks and doctor choices may impact medical care choices for.[11] Later this year, the industry also will need to announce the premiums consumers can expect to pay for policies next year.[12] The administration already has delayed the public's ability to see the plans and prices for next year until mid-November.[13] Questions also remain about whether individuals who were permitted to keep the

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[5] Kyle Cheney, *So how many have paid ACA premiums?*, POLITICO, March 13, 2014. http://www.politico.com/story/2014/03/obamacare-affordable-care-act-health-insurance-premiums-104602.html; Sam Baker, *15-20 Percent Aren't Paying Obamacare Premiums, Insurer Says*, NATIONAL JOURNAL, April 2, 2014. http://www.nationaljournal.com/health-care/15-20-percent-aren-t-paying-obamacare-premiums-insurer-says-20140402.

[6] *Id.*

[7] http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20131008HHS.pdf.

[8] http://energycommerce.house.gov/letter/letter-insurance-providers-federally-facilitated-marketplace.

[9] https://www.healthcare.gov/health-plan-information/.

[10] http://energycommerce.house.gov/letter/letter-insurance-providers-federally-facilitated-marketplace-0.

[11] Sarah Kliff, *Obamacare's narrow networks are going to make people furious—but they might control costs*, WASHINGTON POST, Jan. 13, 2014. http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/13/obamacares-narrow-networks-are-going-to-make-people-furious-but-they-might-control-costs/; Kate Pickert, *Keeping Your Doctor Under Obamacare Is No Easy Feat*, TIME, Jan. 1, 2014. http://swampland.time.com/2014/01/01/keeping-your-doctor-under-obamacare-is-no-easy-feat/.

[12] Jason Millman, *Aetna: Late Obamacare changes account for half of 2015 premium increases*, WASHINGTON POST, April 24, 2014. http://www.washingtonpost.com/blogs/wonkblog/wp/2014/04/24/aetna-late-obamacare-changes-account-for-half-of-2015-premium-increases/.

[13] Devin Dwyer, *White House Delays 2015 Obamacare Enrollment*, ABC NEWS, Nov. 22, 2013. http://abcnews.go.com/blogs/politics/2013/11/white-house-delays-2015-obamacare-enrollment/.

plans they liked will be able to continue to do so, or whether 2014 will feature similar plan cancellations to the millions that occurred in 2013.[14]

III. ISSUES

The following issues may be examined at the hearing:

- What does the industry believe the final enrollment total will be in the PPACA exchanges?
- Are there any states facing unique risk pools or payment problems?
- What has the industry's experience been with HealthCare.gov and the other systems the administration was responsible for creating?
- What can consumers and patients expect to experience regarding networks, doctor choices, and future premiums under the PPACA?

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Sean Hayes or Karen Christian of the Committee staff at (202) 225-2927.

[14] Sam Baker, *Obama Apologizes for Cancelled Health Plans*, NATIONAL JOURNAL, Nov. 7, 2013. http://www.nationaljournal.com/health-care/obama-apologizes-for-cancelled-health-plans-20131107.

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MEMORANDUM

May 7, 2014

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Republicans' Record of False Claims and Predictions about the Affordable Care Act

For nearly five years, Republicans in Congress and their allies have engaged in an unprecedented campaign to sabotage the Affordable Care Act (ACA). They spent hundreds of millions of dollars on advertising campaigns to oppose the law and dissuade uninsured Americans from obtaining health coverage; they cast more than 50 votes to repeal or undermine the law; they refused to expand Medicaid in over 20 states; and they intimidated civic organizations and others involved in educating the public about the law.

Throughout this campaign, Republican leaders have made countless false claims and predictions about the ACA. They predicted after passage of the ACA that "there will be no insurance industry left in three years."[1] They have repeatedly called the law a "train wreck," a "fiasco," and a "catastrophe," despite mounting evidence showing that the exact opposite was true: the Affordable Care Act is providing quality, affordable health insurance to millions of Americans.

This memorandum details thirteen areas where Republicans in Congress made false, misleading, or incorrect claims or predictions about the impact of the Affordable Care Act. Republicans in Congress:

- Falsely claimed that the ACA would lead to the creation of "death panels."
- Incorrectly asserted that the ACA is unconstitutional.
- Falsely claimed that ACA premiums would be unaffordable.
- Inaccurately predicted that the Affordable Care Act would destroy private health insurance.

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[1] *Private Health Insurance in the U.S. Will Be Dead In Three Years*, Tulsa World (Oct. 2, 2010).

- Insisted wrongly that the broken Healthcare.gov website could not be fixed.
- Repeated a series of anecdotes about ACA victims that "deflated like a pricked balloon on the merest examination."
- Falsely claimed that the ACA would result in a reduction in the number of insured Americans.
- Wrongly claimed that the ACA would bankrupt states that decided to expand Medicaid.
- Incorrectly claimed that the ACA would result in a loss of jobs.
- Wrongly claimed that the ACA increases the deficit and increases health care costs.
- Erroneously predicted that the ACA would not meet enrollment goals.
- Misleadingly claimed that many ACA enrollees had not paid their premiums.

The Republican record on the Affordable Care Act is one of willful fallacies. Republican leaders were wrong on every important claim or prediction they made about the impact of the law.

I. INTRODUCTION

Republican falsehoods about the Affordable Care Act began long before it was even signed into law. In 2009, Republicans began spreading myths about "death panels" where "bureaucrats can decide, based on a subjective judgment of [an individual's] 'level of productivity in society,' whether they are worthy of health care."[2] There was no truth to these claims, which were described by Politifact as the 2009 "lie of the year."[3] Days before the law's passage, then-House Minority Leader John Boehner's office wrote that "Democrats have opted for a government takeover of health care that will crush our economy like a ton of bricks."[4]

These false and misleading criticisms continued even after the federal and state marketplaces opened and began to help millions of Americans obtain quality, affordable health insurance. Rep. Michael Burgess described the ACA as a "train wreck for doctors, a train wreck for patients, and, most importantly, it's a train wreck for the American people," while House Budget Committee Chairman Paul Ryan stated, "Obamacare is a slow-rolling fiasco."[5] Senate

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[2] *Sarah Palin's 'death panel' charge voted biggest lie of 2009*, The Los Angeles Times (Dec. 23, 2009) (online at latimesblogs.latimes.com/washington/2009/12/palins-death-panel-charge-voted-biggest-lie-of-2009.html).

[3] *Lie of the Year: Death Panels*, Politifact (Dec. 2009) (online at http://www.politifact.com/truth-o-meter/article/2009/dec/18/politifact-lie-year-death-panels/).

[4] *President Obama Pauses to Sign Jobs Bill While Still Twisting Arms for A Job-Killing Health Care Plan,* Speaker of the House John Boehner (Mar. 17, 2010) (online at www.speaker.gov/general/economists-agree-government-takeover-health-care-massive-job-killer).

[5] *Weekly Addresses: GOP sticks to health care, Obama pivots to the economy,* CNN (Nov. 23, 2013) (online at politicalticker.blogs.cnn.com/2013/11/23/weekly-addresses-gop-sticks-to-health-care-obama-pivots-to-the-economy/); *Paul Ryan's budget makes big Medicare*

Minority Leader Mitch McConnell called the law "a catastrophe for health care and for the economy at large."[6]

When enrollment in the state and federal exchanges exceeded eight million people – well above even the most optimistic expectations – Republicans continued their unfounded criticism of the law. House Majority Whip Kevin McCarthy said in a statement, "Republicans cannot and will not accept this law. Not only will Obamacare still leave millions uninsured while disrupting health care coverage for millions more, it harms jobs, cuts hours, and limits the individual liberty of each and every American."[7]

Commentators have even developed a name for the Republicans' inability to accept the reality of the Affordable Care Act's success: "Obamacare Derangement Syndrome." In an article titled "The Right Can't Admit That Obamacare is Working," columnist Ezra Klein wrote:

> Today, the right struggles with Obamacare Derangement Syndrome: the acute inability to see Obamacare as anything but a catastrophic failure that the American people will soon reject. For those suffering from ODS, all bad Obamacare news is good news, and all good Obamacare news is spin. In this world, delays of minor provisions in the law prove that the entire structure is collapsing, while surges of millions of people enrolling in insurance don't prove anything at all.[8]

II. FALSE REPUBLICAN CLAIMS AND PREDICTIONS ABOUT THE AFFORDABLE CARE ACT

A. Republicans Claim the ACA Will Create "Death Panels"

In 2009, as debate over the law's passage unfolded, former Vice Presidential Candidate and Governor of Alaska Sarah Palin repeatedly claimed that the law would lead to the creation of "death panels" that would decide "based on a subjective judgment of their 'level of productivity in society,' whether [individuals] are worthy of health care."[9]

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changes, Politico (Apr. 2, 2014) (online at www.politico.com/story/2014/04/paul-ryan-budget-medicare-health-care-105234.html).

[6] *McConnell's claim of Obamacare's 'extraordinary disruption' for Americans with health insurance,* Washington Post (Dec. 10, 2013) (online at www.washingtonpost.com/blogs/fact-checker/wp/2013/12/10/mcconnells-claim-of-obamacares-extraordinary-disruption-for-americans-with-health-insurance/).

[7] *Whip McCarthy Responds to the President's Latest Enrollment Announcement,* Rep. Kevin McCarthy, Majority Whip (Apr. 17, 2014) (online at www.majoritywhip.gov/press-release/whip-mccarthy-responds-president%E2%80%99s-latest-enrollment-announcement).

[8] *The right can't admit that Obamacare is working,* Vox (Apr. 14, 2014) (online at www.vox.com/2014/4/14/5613094/obamacare-derangement-syndrome).

[9] *Sarah Palin Falsely Claims Barack Obama Runs a 'Death Panel',* Politifact (Aug. 10, 2009) (online at www.politifact.com/truth-o-meter/statements/2009/aug/10/sarah-palin/sarah-palin-barack-obama-death-panel/).

The statements were immediately rejected as false by independent media organizations. The *Washington Post* listed it as one of the "whoppers" of 2009.[10] Politifact described it as the "lie of the year."[11] But Republican members of Congress continued to repeat this false claim. Then-House Minority Leader John Boehner and Rep. Thaddeus McCotter released a statement saying that ACA "may start us down a treacherous path toward government-encouraged euthanasia."[12]

In fact, Governor Palin has continued to make this false claim, stating as recently as August 2013 that "of course there are death panels."[13]

B. Republicans Claim the ACA Is Unconstitutional

During a December 2009 vote on the health reform law, every Senate Republican voted to declare the ACA's individual mandate unconstitutional.[14] House Majority Leader Eric Cantor and House Energy and Commerce Committee Chairman Fred Upton each flatly called the Affordable Care Act an "unconstitutional law."[15] Rep. Steve King predicted that the Supreme Court would rule that the individual mandate was unconstitutional and overturn the entire law.[16] Rep. Michael Burgess also said, "I'm confident [opponents] will prevail in defeating the unconstitutional individual mandate and voiding the entire statute."[17]

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[10] *Whoppers of 2009*, Washington Post (Dec. 24, 2009) (online at www.factcheck.org/2009/12/whoppers-of-2009/).

[11] *Sarah Palin Falsely Claims Barack Obama Runs a 'Death Panel'*, Politifact (Aug. 10, 2009) (online at www.politifact.com/truth-o-meter/statements/2009/aug/10/sarah-palin/sarah-palin-barack-obama-death-panel/).

[12] *Proposed Counseling for Seniors in Health Plan Spurs New Battle,* Washington Post (Aug. 1, 2009) (online at www.washingtonpost.com/wp-dyn/content/article/2009/07/31/AR2009073103148.html).

[13] *Cashin' In*, Fox News (Aug. 10, 2013)

[14] *Unpopular Mandate,* The New Yorker (June 25, 2012) (online at www.newyorker.com/reporting/2012/06/25/120625fa_fact_klein?currentPage=all).

[15] *Virginia judge rules health care mandate unconstitutional,* CNN (Dec. 13, 2010) (online at www.cnn.com/2010/POLITICS/12/13/health.care/); *Upton, Pitts Welcome Latest Court Ruling that Finds Individual Mandate Unconstitutional,* House Energy and Commerce Committee, Majority Staff (Aug. 11, 2011) (online at energycommerce.house.gov/press-release/upton-pitts-welcome-latest-court-ruling-finds-individual-mandate-unconstitutional).

[16] *Steve King Predicts Supreme Court Will Rule ObamaCare Unconstitutional,* Iowa Republican (Apr. 4, 2012) (online at theiowarepublican.com/2012/steve-king-predicts-supreme-court-will-rule-obamacare-unconstitutional/).

[17] *Burgess Statement Regarding Michigan Judge Ruling On Individual Mandate,* Congressman Michael C. Burgess (Oct. 7, 2010) (online at burgess.house.gov/news/documentsingle.aspx?DocumentID=211234).

These predictions were wrong. In June 2012, the Supreme Court upheld the ACA's individual mandate as constitutional.

Yet even after this ruling, Republicans continued to claim that the mandate was not constitutional. Senator Rand Paul said, "Just because a couple people on the Supreme Court declare something to be 'constitutional' does not make it so. The whole thing remains unconstitutional."[18]

C. Republicans Claim the ACA Is a Government Takeover that will Destroy Private Health Insurance

Republican leaders have repeatedly claimed that the Affordable Care Act will end private insurance coverage. Days before the law's passage, then-House Minority Leader John Boehner's office wrote that "Democrats have opted for a government takeover of health care that will crush our economy like a ton of bricks."[19] Sen. Tom Coburn had an even more dire prediction, stating that "there will be no insurance industry left in three years."[20]

These predictions have proven to be false. The private insurance industry remains robust.

D. Republicans Claim Premiums Will Be Unaffordable

In the weeks and months before the opening of the federal and state marketplaces, Republicans repeatedly claimed that premiums would dramatically increase and would be unaffordable. At a hearing of the Subcommittee on Health in March 2013, Rep. Joe Pitts claimed that "Americans' premiums have already risen by more than $3,000" and predicted that "premiums will only grow more unaffordable for Americans."[21] In May 2013, the Republican staff of the House Energy and Commerce Committee released a report predicting that consumers could see premium increases averaging 100% in the individual market, with increases as high as 400% possible.[22] House Majority Leader Eric Cantor also claimed, "It is now projected that

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[18] *Rand Paul: 'Obamacare' is still unconstitutional,* Politico (June 28, 2012) (online at www.politico.com/blogs/on-congress/2012/06/rand-paul-obamacare-is-still-unconstitutional-127574.html).

[19] *President Obama Pauses to Sign Jobs Bill While Still Twisting Arms for A Job-Killing Health Care Plan,* Speaker of the House John Boehner (Mar. 17, 2010) (online at www.speaker.gov/general/economists-agree-government-takeover-health-care-massive-job-killer).

[20] *Private Health Insurance in the U.S. Will Be Dead In Three Years*, Tulsa World (Oct 2, 2010).

[21] House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on Unaffordable: Impact of Obamacare on Americans' Health Insurance Premiums,* 113th Cong. (Mar. 15, 2013).

[22] House Committee on Energy and Commerce, Majority Staff, *Obamacare Oversight: the Looming Premium Rate Shock,* 113th Cong. (May 13, 2013).

ObamaCare will send health care premiums skyrocketing in the individual and small group insurance markets."[23] Even after premiums were released in October 2013, Senator Ted Cruz said: "President Obama promised the American people Obamacare would lower your health insurance premiums. I would venture to say virtually every person across this country has seen exactly the opposite happen, has seen premiums going up and up and up."[24]

In reality, marketplaces premiums came in 16% lower than the nonpartisan Congressional Budget Office (CBO) had originally predicted.[25] Americans flocked to the marketplaces, with premiums low enough that enrollment exceeded expectations. More than half of the uninsured were eligible for coverage that would cost them less than $100 per month.[26] CBO projects that the average premium for the benchmark silver plan will rise only 3% in 2015, well below historic rates of premium increases.[27]

E. Republicans Claim Healthcare.gov Could Not Be Fixed

Republicans held multiple hearings on the technical problems with Healthcare.gov in October and November of last year. Some predicted that the website could never be fixed and that the Administration would have to start over and build an entirely new website for the federal marketplace. Rep. Bill Johnson wrote in an editorial titled "Healthcare.gov can't be fixed," that "the problems with the Healthcare.gov website are catastrophic."[28] During an Energy and Commerce Committee hearing on October 24, 2013, he stated, "these are more than glitches. They can't be fixed."[29]

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[23] *Congressman Cantor: Obamacare is Not the Answer,* Congressman Eric Cantor (May 16, 2013) (online at cantor.house.gov/speeches/2013/05/congressman-cantor-obamacare-not-answer/).

[24] *Sen. Ted Cruz says premiums have gone 'up and up and up' for 'virtually every person,'* PolitiFact (Oct. 17, 2013) (online at www.politifact.com/truth-o-meter/statements/2013/oct/17/ted-cruz/sen-ted-cruz-says-premiums-have-gone-virtually-eve/).

[25] Department of Health and Human Services, *Significant choice and lower than expected premiums available in the new Health Insurance Marketplace* (Sept. 25, 2013) (online at www.hhs.gov/news/press/2013pres/09/20130925a.html).

[26] Department of Health and Human Services, *Nearly 6 in 10 uninsured Americans can pay less than $100 per month for coverage in the Health Insurance Marketplace* (Sept. 17, 2013) (online at www.hhs.gov/news/press/2013pres/09/20130917b.html).

[27] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Apr. 2014) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf).

[28] *Healthcare.Gov can't be fixed,* The Hill (Oct. 30, 2013) (online at thehill.com/blogs/congress-blog/healthcare/188572-healthcaregov-cant-be-fixed).

[29] House Committee on Energy and Commerce, *Hearing on PPACA Implementation Failures: Didn't Know or Didn't Disclose?* 113th Cong. (Oct. 24, 2013).

This prediction proved to be false. The Administration brought in management expert Jeffrey Zients to oversee the efforts to improve Healthcare.gov, and by December 1, Mr. Zients and his team had made over 400 software fixes, increased the site's capacity, and reduced page response times and error rates, dramatically improving the experience for consumers.[30]

In total, there were over 67 million visits to Healthcare.gov and over 31 million visits to the websites for the state-based marketplaces by April 19, 2014.[31] On March 31, the last official day of the initial open enrollment period, Healthcare.gov handled 4.8 million visits.[32] Ultimately, over eight million Americans signed up for insurance coverage via Healthcare.gov or state exchanges.

F. Republicans Claim Obamacare Has Harmed Individual "Victims"

On numerous occasions, Republican leaders and conservative activists have repeated stories of individuals who appear to have lost coverage or faced increased costs due to the Affordable Care Act. These stories have not been able to withstand scrutiny.

One anecdote told by Republicans involved Ashley Dionne, who claimed the ACA would raise her premium from $75 per month to $319 per month.[33] In fact, because Ms. Dionne would likely qualify for Medicaid or tax credits, she could either pay no monthly premium for Medicaid or pay $23 per month for a quality silver-level plan, well below her current costs.[34] Since Ms. Dionne stated that she has a number of pre-existing conditions, the ACA would protect her from being charged higher rates as a result of these conditions.[35]

Another anecdote involved Dianne Barrette, who received a cancellation letter for a health plan that cost $54 per month.[36] But Ms. Barrette's previous plan would reimburse only a

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[30] Department of Health and Human Services, *Operational Progress Report* (Dec. 1, 2013) (online at www.hhs.gov/digitalstrategy/blog/2013/12/operational-progress-report.html).

[31] Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (May 1, 2014) (online at aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf).

[32] Department of Health and Human Services, *7.1 Million Americans Have Enrolled in Private Health Coverage Under the Affordable Care Act* (Apr. 1, 2014) (online at www.hhs.gov/healthcare/facts/blog/2014/04/more-7-million-americans-are-signed-private-health-coverage.html).

[33] *Huckabee*, Fox News Channel (Oct. 12, 2013).

[34] *Good News: Obamacare Hasn't 'Raped' the Future of This 26-Year-Old*, The Atlantic Wire (Oct. 10, 2013) (online at www.thewire.com/politics/2013/10/good-news-obamacare-raped-future-26-year-old/70397/).

[35] *Id.*

[36] *CBS Evening News*, CBS (Oct. 28, 2013) (online at www.cbsnews.com/news/policy-cancellations-higher-premiums-add-to-frustration-over-obamacare/).

maximum of $50 per doctor visit and $15 per prescription drug, and it did not cover hospitalizations except in the case of a complicated pregnancy, when it would pay only $50. When she was alerted to the fact that she could likely purchase the comprehensive coverage in the marketplace for $150 or $200 per month, she recognized that the Affordable Care Act provided her with better options than the status quo. She said that she "would jump at it. ... With my age, things can happen. I don't want to have bills that could make me bankrupt. I don't want to lose my house.'"[37]

Other anecdotes told by Republicans to foster fear about the new law featured individuals who either misstated the impact of the law on their coverage options, chose not to take advantage of newly available tools to reduce costs and improve coverage, or were otherwise unaware that they now have access to coverage that is higher quality and more affordable than their prior coverage. As the *Los Angeles Times* stated: "virtually every yarn promoted by Republicans or conservatives about people hurt by the Affordable Care Act has deflated like a pricked balloon on the merest examination."[38]

G. Republicans Claim Medicaid Expansion Is Unaffordable

In more than 20 states, Republican governors and state legislatures have refused to expand lifesaving Medicaid coverage to millions of uninsured Americans, often citing the costs that states will have to cover as an issue. South Carolina Governor Nikki Haley said that Medicaid expansion would "bust our budgets."[39] Rep. Joe Barton also stated that expanding Medicaid would "leav[e] already cash strapped state budgets to deal with crushing costs and a more burdensome bureaucracy."[40] In a letter to Health and Human Services Secretary Kathleen Sebelius, Texas Governor Rick Perry wrote that the ACA's Medicaid expansion would "threaten even Texas with financial ruin."[41]

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[37] *The Media Labeled Her an Obamacare Victim. Here's What She Really Thinks*, The New Republic (Nov. 3, 2013) (online at www.newrepublic.com/article/115457/obamacare-victim-florida-happy-she-can-get-real-coverage); *That Florida woman's canceled Blue Cross policy? It's junk insurance*, Consumer Reports (Oct. 29, 2013) (online at www.consumerreports.org/cro/news/2013/10/florida-woman-s-canceled-blue-cross-plan-is-junk/index.htm).

[38] *Maybe There are no Genuine Obamacare Horror Stories*, Los Angeles Times (Feb. 21, 2014) (online at www.latimes.com/business/hiltzik/la-fi-mh-obamacare-horror-stories-20140220,0,3801120.story#ixzz2uIBuwSie).

[39] *Live Updates: Mitt Romney, Paul Ryan, Donald Trump to Speak at Second Day of CPAC 2013,* ABC News (Mar. 15, 2013) (online at abcnews.go.com/blogs/politics/2013/03/live-updates-mitt-romney-paul-ryan-donald-trump-to-speak-at-second-day-of-cpac-2013/).

[40] Office of the Governor Rick Perry, *Gov. Perry, Sen. Cornyn, Sen. Cruz: Texas Stands Firm Against Medicaid Expansion* (Apr. 1, 2013) (online at governor.state.tx.us/news/press-release/18316/).

[41] Letter from Governor Rick Perry to Secretary Kathleen Sebelius (July 9, 2012).

In reality, the federal government covers 100% of the cost of Medicaid expansion for the first three years, slowly decreasing to a permanent matching rate of 90% in 2020.[42] States that refuse to expand are turning down millions and even billions of dollars from the federal government: in 2022, Texas would receive $9.2 billion, Florida would receive over $5 billion, and South Carolina would receive over $800 million.[43] A Commonwealth Fund analysis found that states that do not expand Medicaid would still spend millions of dollars on uncompensated care and other costs, and "no state would experience a positive flow of funds by choosing to reject the Medicaid expansion."[44]

H. Republicans Claim More People Will Lose Coverage Than Gain Coverage under the ACA

One easily disprovable claim made by Republicans was that the ACA would result in fewer insured Americans than there had been prior to the law's passage. At the end of 2013, Chairman Fred Upton stated, "come January 1, 2014, millions more people will have lost their prior coverage than signed up because of the health care law."[45] In a press conference in March, Speaker Boehner said "there are less people today with health insurance than there were before this law went into effect."[46] Senator Marco Rubio said that during open enrollment, "[t]he Administration is recognizing the grim reality that more Americans have lost health insurance than gained it under ObamaCare."[47]

In fact, multiple analyses indicate that the ACA has led to a substantial decrease in the number of uninsured Americans. Gallup reported earlier this week that the percentage of uninsured adults fell to 13.4% in April 2014, its lowest level since Gallup began tracking this

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[42] Department of Health and Human Services, *HHS finalizes rule guaranteeing 100 percent funding for new Medicaid beneficiaries* (Mar. 29, 2013) (online at www.hhs.gov/news/press/2013pres/03/20130329a.html).

[43] *Study: Refusing Medicaid expansion will cost states billions of dollars,* Washington Post (Dec. 6, 2013) (online at www.washingtonpost.com/blogs/govbeat/wp/2013/12/06/study-refusing-medicaid-expansion-will-cost-states-billions-of-dollars/).

[44] *Id.*

[45] *What #Obamacare Looks Like When Enrollment is Abandoned as Measure of Success,* House Energy and Commerce Committee, Majority Staff (Dec. 18, 2013) (online at energycommerce.house.gov/press-release/what-obamacare-looks-when-enrollment-abandoned-measure-success).

[46] *John Boehner Says More People Are Uninsured Since Obamacare Took Effect,* Politifact (Mar. 14, 2014) (online at www.politifact.com/truth-o-meter/statements/2014/mar/18/john-boehner/john-boehner-says-more-people-are-uninsured-obamac/).

[47] *The GOP Claim That More Americans Have Lost Insurance Than Gained it Under Obamacare*, Washington Post (Jan. 6, 2014) (online at www.washingtonpost.com/blogs/fact-checker/wp/2014/01/06/the-gop-claim-that-more-americans-have-lost-insurance-than-gained-it-under-obamacare/).

number in January 2008. The Gallup poll found that "the uninsured rate was lower in April than in the fourth quarter of 2013 across nearly every key demographic group.[48] This represents a drop of 4.6 percentage points from before the most recent open enrollment period began in October, corresponding to over 11 million people gaining insurance.[49] Similar analyses from Rand and the Urban Institute found major gains in the number of Americans with health insurance following open-enrollment.[50] A recent panel of health insurers, including the Chief Executive Officer of America's Health Insurance Plans and representatives from other major insurers, also agreed that "the number of insured people in the country has climbed by millions, despite arguments by some Republicans that the insured population has declined."[51]

I. Republicans Claim the ACA Will Cause Job Loss

Republicans have claimed that the ACA will be a "job-killer" since before it was even signed into law. During debate over passage of the law in 2009, Rep. Paul Broun of Georgia predicted that the ACA was "going to destroy [the] economy. It is going to destroy jobs."[52] In 2011, Speaker Boehner called the ACA "the biggest job killer we have in America today," while House Majority Leader Eric Cantor called it "a job killing health care bill that spends money we don't have."[53] Vice Chairman of the Health Subcommittee Rep. Michael Burgess said during a hearing in 2013 "as we get closer and closer ... to full implementation, it becomes apparent that

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[48] *U.S. Uninsured Rate Drops to 13.4%,* Gallup (May 5, 2014) (online at www.gallup.com/poll/168821/uninsured-rate-drops.aspx).

[49] *Poll: Nation's Uninsured Rate Hits Lowest Point Since 2008*, Talking Points Memo (May 5, 2014) (online at talkingpointsmemo.com/livewire/gallup-uninsured-rate-may-all-time-low?utm_content=bufferf0013&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer).

[50] *Survey Estimates Net Gain of 9.3 Million American Adults With Health Insurance,* RAND (Apr. 8, 2014) (online at www.rand.org/blog/2014/04/survey-estimates-net-gain-of-9-3-million-american-adults.html); *Early Estimates Indicate Rapid Increase in Health Insurance Coverage Under the ACA: A Promising Start*, The Urban Institute (Apr. 15, 2014) (online at /hrms.urban.org/briefs/early-estimates-indicate-rapid-increase.html).

[51] *Insurers: Millions More Have Coverage Now*, Politico (Apr. 29, 2014) (online at www.politico.com/story/2014/04/insurers-millions-more-have-coverage-now-106134.html#ixzz30xPhL5W8).

[52] U.S. House of Representatives, Floor Statement by Rep. Paul Broun (Nov. 5, 2009) (online at www.gpo.gov/fdsys/pkg/CREC-2009-11-05/pdf/CREC-2009-11-05-pt1-PgH12368-7.pdf#page=1).

[53] *Boehner on NBC Nightly News: "ObamaCare is the Biggest Job-Killer We Have in America Today,"* Speaker John Boehner (Jan. 6, 2011) (online at www.speaker.gov/general/boehner-nbc-nightly-news-%E2%80%9Cobamacare-biggest-job-killer-we-have-america-today%E2%80%9D#sthash.CX6jlMbG.dpuf); *Transcript: Majority Leader-Elect Eric Cantor's Pen & Pad,* Majority Leader Eric Cantor (Jan. 5, 2011) (online at majorityleader.gov/newsroom/2011/01/transcript-majority-leader-elect-eric-cantors-pen-pad.html).

job loss, not job creation is the actual result."[54] Rep. Pete Olson claimed, "There are many job-killing, growth-stunting parts of Obamacare."[55] Rep. Tim Murphy, Chairman of the Oversight and Investigations Subcommittee, said that "nearly one-fifth of the Nation's small businesses have reduced employment because of the Affordable Care Act."[56]

These predictions have been proven wrong. In the four years since the passage of the Affordable Care Act, the U.S. economy has created 9.1 million jobs, with job growth in every single month, and the unemployment rate has declined more than three percentage points since the President signed the bill into law.[57]

J. Republicans Claim the ACA Will Increase the Deficit

Republicans have repeatedly claimed that the Affordable Care Act will add to the nation's deficit. Before the law was even passed, Budget Committee Chairman Paul Ryan, said, "This bill does not control costs. This bill does not reduce deficits."[58] In 2013, during an all-night filibuster that led to the government shutdown, Senator Ted Cruz decried the ACA as a "debt-exploding, out of control government mess."[59] Vice Chairman of the Energy and Commerce Committee Marsha Blackburn actually claimed the CBO had increased the overall projected cost of the ACA each time they had reviewed it, saying on the House floor "my source on this is the Congressional Budget Office, the CBO. Every time [the ACA] has been reviewed ... guess what has happened? The cost estimate has gone up."[60]

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[54] House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, *Hearing on Challenges Facing America's Businesses under the Patient Protection and Affordable Care Act,* 113th Cong. (June 26, 2013).

[55] *Id.*

[56] *Id.*

[57] *Jobs Report: Over 9 million Private-Sector Jobs created Since Obamacare Passed,* Daily Kos (May 2, 2014) (online at www.dailykos.com/story/2014/05/02/1296328/-Jobs-Report-Over-9-Million-Private-Sector-Jobs-Created-Since-Obamacare-Passed).

[58] *Transcript: White House Health Summit, Afternoon Session,* Kaiser Health News (Feb. 26, 2010) (online at www.kaiserhealthnews.org/Stories/2010/February/26/Summit-Transcript-Afternoon.aspx).

[59] *Transcript: Sen. Ted Cruz's Marathon Speech Against Obamacare on Sept. 24,* Washington Post (Sept. 25, 2013) (online at www.washingtonpost.com/sf/national/2013/09/25/transcript-sen-ted-cruzs-filibuster-against-obamacare/).

[60] U.S. House of Representatives, Floor Speech by Rep. Marsha Blackburn (Oct. 15, 2013) (online at wwww.blackburn.house.gov/videos/?VideoID=PsJV17dERNE).

These claims are not correct. The CBO has repeatedly found that the ACA will reduce the deficit. When the ACA was passed in 2010, CBO found that it would reduce the deficit by $143 billion in the first decade, and by over $1 trillion in the next decade.[61]

In last month's updated review of the ACA's impact on spending, CBO reported that "a year-by-year comparison shows that ... estimates of the net budgetary impact of the ACA's insurance coverage provisions have decreased, on balance, over the past four years."[62] CBO again concluded, "the ACA's overall effect would be to reduce federal deficits."[63]

K. Republicans Claim the ACA Will Raise Health Care Costs

Republicans have also continually claimed that the ACA is fueling rising healthcare spending. Immediately after the law's passage, Speaker Boehner released a report which concluded, "American families and small businesses have been left with higher costs, more spending, and more debt."[64] Rep. Michael Burgess predicted in 2011, "We've got the other looming problem in 2014, when the spending really accelerates out of the Affordable Care Act that's really going to be disruptive to the budget."[65] Earlier this year, Rep. Joe Pitts said in a statement about the ACA that "[g]iving Washington more control will never solve the problem most Americans have with health care: rising costs."[66]

In fact, health care cost growth has slowed since the law's passage. In the three years after passage of the ACA, health care spending growth was at its lowest level on record.[67] Health care inflation is at its lowest rate in 50 years. Per capita Medicare spending rose just

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[61] Congressional Budget Office, *Cost Estimate for Pending Health Care Legislation,* (Mar. 21, 2010) (online at cbo.gov/publication/25049).

[62] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf).

[63] *Id.*

[64] *Obamacare: Three Months of Broken Promises*, Office of the Republican Leader, (June 23, 2010) (online at www.speaker.gov/sites/speaker.house.gov/files/UploadedFiles/ObamaCare3MonthsBrokenPromises.pdf).

[65] *Burgess: Delay ACA Implementation Until High Court Rules to Save Money,* Congressman Michael C. Burgess (Aug. 18, 2011) (online at burgess.house.gov/news/documentsingle.aspx?DocumentID=256684).

[66] *Pitts Releases Updated Memo on Health Care Reform,* Congressman Joe Pitts (Feb. 20, 2014) (online at pitts.house.gov/press-release/pitts-releases-updated-memo-health-care-reform).

[67] The White House, *Trends in Health Care Cost Growth and the Role of the Affordable Care Act* (Nov. 2013) (online at http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf).

0.7% in 2012, compared to a 5.4% annual increase only five years ago.[68] And CBO continues to find that health care costs have increased at a rate slower than they anticipated.[69]

L. Republicans Claim the ACA Would Not Meet Coverage Goals

Republicans have predicted on multiple occasions that the Administration would fail to reach CBO's initial projection of seven million people signing up for private health insurance through the federal and state marketplaces. After the first month's enrollment numbers came out, Speaker John Boehner called the law "a rolling calamity that must be scrapped," while Rep. Renee Ellmers issued a statement saying that "if the numbers released today are accurate, the law is truly collapsing quicker than anyone would have imagined."[70] Rep. Darrell Issa said in a statement that the "27,000 enrollments through federally facilitated exchange pale in comparison to the millions of Americans who have lost their health insurance under ObamaCare."[71] Sen. Orrin Hatch said in a statement, "at this pace, the Obama Administration will never be able to meet their enrollment goals."[72] Speaker John Boehner more recently called enrollment "dismal," adding that "the President's push to enroll young adults is far too little, too late."[73]

The Affordable Care Act not only met CBO's first-year enrollment goal, it exceeded it. Over eight million people have now signed up for private health insurance plans through the federal and state marketplaces created under the ACA. Enrollments surged at the end of the initial enrollment period, with nearly 3.8 million people selecting a plan after March 1, 2014.[74]

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[68] *U.S. healthcare costs keep rising but at slower pace*, Los Angeles Times (Jan. 6, 2014) (online at www.latimes.com/business/la-fi-0107-healthcare-spending-20140107,0,7267579.story#ixzz2qITSK386).

[69] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf).

[70] *GOP rips Obamacare enrollment figures,* CNN (Nov. 13, 2013) (online at www.cnn.com/2013/11/13/politics/gop-obamacare-reaction/); *Ellmers: If True, Obamacare Enrollment Numbers are Pathetic,* Congresswoman Renee Ellmers (Oct. 10, 2013) (online at ellmers.house.gov/latest-news/ellmers-if-true-obamacare-enrollment-numbers-are-pathetic/).

[71] *Issa Statement on Low ObamaCare Enrollment Numbers,* Congressman Darrell Issa (Nov. 13, 2013) (online at issa.house.gov/press-releases/2013/11/issa-statement-on-low-obamacare-enrollment-numbers/).

[72] *Hatch Statement on Obamacare Enrollment Numbers,* Senator Orrin Hatch (Nov. 23, 2013) (online at www.hatch.senate.gov/public/index.cfm/releases?ID=490afe84-b4a2-4cb8-a432-442a3cac835e).

[73] *New Report Shows Administration Lagging Far Behind ObamaCare Enrollment Goals*, Fox News (Mar. 11, 2014) (online at: www.foxnews.com/politics/2014/03/11/administration-lagging-far-behind-obamacare-enrollment-goals/).

[74] Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (May 1, 2014) (online at aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf).

Additionally, 4.8 million individuals enrolled in Medicaid and CHIP between October 2013 and March 2014.[75] CBO estimates that five million people also purchased ACA-compliant plans outside of the marketplaces this year.[76]

M. Republicans Claim Individuals Have Not Paid Their Premiums

The most recent example of incorrect and misleading claims by Republicans about the Affordable Care Act is the claim that few people have paid their ACA premiums. An April 30, 2014, analysis by the Republican staff of the Energy and Commerce Committee reported that only 67% of individuals who had signed up for an ACA plan through the federal and state marketplaces had paid their premiums.[77] Chairman Fred Upton claimed, "the administration's recent declarations of success may be unfounded."[78]

But this report was flawed and incomplete because it was based on premium payment data from April 15, 2014. At that time, many ACA enrollees were not yet required to pay their premiums.[79] By April 15, eight million people had enrolled through the ACA exchanges. Three million of these enrollees signed up after March 15, 2014, and for these individuals, premiums were not due until the end of April at the earliest.

Additional recent data from insurers shows that the conclusions by the Republican staff were not correct. The Blue Cross Blue Shield Association, whose member companies offer plans in almost every ACA marketplace, indicated that between 80% to 85% of individuals had paid their premiums by the end of April.[80] The CEO of America's Health Insurance Plans, the

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[75] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: March 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report* (May 1, 2014) (online at www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/March-2014-Enrollment-Report.pdf).

[76] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf).

[77] *Committee Learns Who's Paid for Obamacare: As of April 15, Only 67 Percent of Enrollees in Federal Marketplace Had Pain First Month's Premium*, Committee on Energy and Commerce, Majority Staff (Apr. 30, 2014) (online at energycommerce.house.gov/press-release/committee-learns-who%E2%80%99s-paid-obamacare-april-15-only-67-percent-enrollees-federal).

[78] *Id.*

[79] See Memorandum from Democratic Staff to Democratic Members and Staff of the House Committee on Energy and Commerce, Misleading Republican Report on ACA Enrollment (Apr. 30, 2014).

[80] *Blue Cross Says '80-85' Percent of Obamacare Enrollees Are Paying*, Forbes (Apr. 2, 2014) (online at www.forbes.com/sites/brucejapsen/2014/04/02/blue-cross-plans-say-80-to-85-percent-of-obamacare-enrollees-are-paying/).

industry trade group, stated this week that 85% of individuals enrolled in exchange plans have paid their premiums.[81]

III. CONCLUSION

Repeatedly over the last five years, Republicans in Congress have made inaccurate claims and predictions about the Affordable Care Act. They have been wrong about the constitutionality of the law, wrong about the law's impact on premium cost and affordability and health care spending, wrong about the impact of the law on health care coverage, wrong about the impact of the law on jobs, wrong about the impact of the flawed rollout of Healthcare.gov, and wrong about the extent to which the law's state and federal exchanges would meet enrollment goals. Last week, they were wrong about how many ACA enrollees were actually paying premiums.

Contrary to the Republican claims, the factual evidence indicates that the law is working. It has reduced health care costs and provided affordable, quality coverage for millions of Americans.

[81] Briefing by Karen Ignagni, President and CEO of America's Health Insurance Plans, to Politico Pro Health Care Breakfast (Apr. 29, 2014).

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
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Majority (202) 225-2927
Minority (202) 225-3641

June 27, 2014

Mr. Mark Pratt
Senior Vice President of State Affairs
America's Health Insurance Plans
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, D.C. 20004

Dear Mr. Pratt:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 7, 2014, to testify at the hearing entitled "PPACA Enrollment and the Insurance Industry."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Friday, July 11, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

July 11, 2014

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
House Energy and Commerce Committee
2125 Rayburn Building
Washington, D.C. 20515

Dear Chairman Murphy:

I am writing in response to your letter of June 27, 2014 to provide answers to the questions that were submitted in writing by members of the subcommittee. My responses are included in the attached document.

Sincerely,

[redacted]

Mark C. Pratt

Attachment

cc: The Honorable Diana DeGette, Ranking Member

House Energy and Commerce Committee Hearing
on "PPACA Enrollment and the Insurance Industry"
May 7, 2014
Responses to Questions for the Record
by Mark Pratt, Senior Vice President, State Affairs, America's Health Insurance Plans

Questions From the Honorable Marsha Blackburn:

1. Mr. Pratt, has your organization done any analysis on whether consumers have been able to keep the doctors or medical providers they enjoyed prior to full implementation of the health care law? Please describe this analysis and submit it for the record.

   AHIP Response: AHIP recently commissioned a report from Milliman that examines how health plans use provider networks as a tool to keep costs down and to ensure that their members are receiving high quality care. The report describes how collaborative relationships between health plans and providers are leveraged to improve outcomes, as well as how provider networks are integrated into the health plan's benefit design. Moreover, the authors found that the use of high-value provider networks results in a 5 to 20 percent reduction of premiums. The full report is available at www.ahip.org/MillimanReportHPN2014/.

2. Has your organization done any analysis on the networks of providers offered by providers selling plans on the federal exchange? Please describe this analysis and submit it for the record.

   AHIP Response: Please see the response to Question 1 above.

Questions From the Honorable Michael C. Burgess:

1. While some of the basic problems with the front-end components that individuals face on HealthCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.

   a. Have any significant improvements been made to these components?

      AHIP Response: While improvements have been made, much work remains to address several outstanding issues for full functionality of the federally-facilitated Marketplace (FFM). Work is now underway to reconcile enrollment data between health plans and the FFM – a key step to ensure consistency in the data between the FFM and the insurer that will be completed by early Fall. Plans continue to use manual and semi-automated processes to process special enrollment period enrollments through the temporary Change in Circumstance

(CIC) functionality as the FFM does not have the functionality to support a fully automated solution for insurers.

b. How will these continued problems affect plan participation and premiums for 2015?

AHIP Response: We do not have sufficient information to make these types of projections.

2. 834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.

a. Has this been your experience?

AHIP Response: As reported in my testimony, health plans have had to continue to perform manual processes and work-arounds that were necessitated by the problems that surfaced in the days and weeks following the October 1 launch and outstanding back-end issues. We are not in a position to provide information on specific failure rates.

b. What is your estimation of the failure rate?

AHIP Response: As we do not process enrollments directly, we are not in a position to comment on the specific failure rate of 834 files.

c. Has the failure rate improved over time and by how much?

AHIP Response: As we do not process enrollments directly, we are unable to comment on the specific failure rate of 834 files. As I mentioned above, our plans have indicated there are improvements, but 834s in response to "Life events" still require manual processing to ensure accurate enrollment data and premium rates.

d. What problems has this caused for your companies, your enrollees, and contracted providers?

AHIP Response: Our member companies have been doing everything possible to ensure that back-end problems do not negatively impact health plan enrollees and contracted providers. However, we are aware of reports that 834 challenges can be error-prone and have negatively impacted some consumers.

3. Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.

a. Do you have an estimation of the number of duplicate enrollments in your system?

AHIP Response: As I indicated in my testimony, some consumers were advised to create a new account and enroll again. As a result, insurers have many duplicate enrollments in their system for which they never received any payment. In cases where an insurer has a new enrollment for a consumer who previously enrolled, they are not expecting that original policy to be effectuated – even though that data is still reported. However, as we do not process enrollments directly, we are not in a position to provide specific numbers of duplicate enrollments.

b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

AHIP Response: We do not have any information in this area.

4. The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.

a. If enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?

AHIP Response: As mentioned in the question, health insurers have the option of only paying claims during the first month of the three-month grace period and pending claims during the second and third months. While our members are taking various approaches to implement the regulations, we do understand that most health plans are not paying claims during the entirety of the grace period. However, we do want to point out the requirements in the regulations and CMS guidance that health insurers are required to notify providers if their patients are currently in the grace period.

b. If you do not pay the claims, who will make providers whole?

AHIP Response: We understand that upon receipt of outstanding premium payment, health plans will re-process any pended claims and reimburse the providers according to existing agreements. If the enrollee does not pay past due amounts, the provider may seek payment from the enrollee.

c. Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?

AHIP Response: For those health insurers that choose to only pay claims during the first month of the grace period, they will pay those claims using existing processes. During the second and third months, health plans have the option to pend claims, thus there is no reconciliation process necessary. As indicated above, upon receipt of premium payment, health plans will pre-process claims and pay using existing processes.

d. Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.

AHIP Response: We do not have any such data.

5. One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.

a. Do you know how many enrollees are currently covered but behind on paying their premiums?

AHIP Response: No.

b. The law says that you must provide this information to HHS. Are you doing so?

AHIP Response: Per existing CMS guidance, in the FFM, health plans were required to report this information to CMS as part of the required monthly enrollment reconciliation. However, this process has not yet been fully implemented. In addition, upon termination for non-payment of premium, health plans are required to send a termination 834 file to CMS which will indicate the reason for termination as "non-payment of premium."

c. What is the process for communicating with providers when enrollees enter a grace period?

AHIP Response: In accordance with 45 C.F.R. §156.270(d)(3) and CMS guidance, health insurers must notify providers that may be affected (meaning at least providers that submit claims for services rendered during the grace period) that an enrollee has lapsed in his or her payment of premiums. Issuers may utilize automated electronic processes to convey such notices. The notice must indicate there is a possibility that the issuer may deny payment of claims incurred during the second and third months of the grace period if the enrollee exhausts the grace period without paying the premiums in full. Insurers are required to notify all potentially affected providers as soon as is practicable when an enrollee enters the grace period.

6. Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.

   a. Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?

      AHIP Response: On a monthly basis, health insurers are submitting enrollment and other data so that CMS may provide premium and cost-sharing subsidies to insurers. As part of this process, to provide updated information about regular enrollment changes, in addition to submitting information about the current month, health insurers are also making adjustments to past months (e.g., in the case of an incorrect enrollment or retroactive termination). We are not in a position to answer questions regarding the process to correct subsidy information for those individuals that have an "inconsistency" at this time.

   b. Please describe the process if there is a process in place.

      AHIP Response: Please see the response to Question 6(a.).

   c. If there is a process, have any miscalculated payments been reconciled?

      AHIP Response: Please see the response to Question 6(a.).

   d. If miscalculated payments have been reconciled, how many have been processed?

      AHIP Response: We are not in a position to answer this question.

   e. Please provide an estimation for the administrative cost of these miscalculations if possible.

      AHIP Response: We are not in a position to answer this question.

   f. How might the miscalculation of payments affect plans for next year in terms of participation or premiums?

      AHIP Response: We are not in a position to answer this question.

7. The ACA imposes an annual health insurance industry fee on carriers based on their proportion of market share.

   a. How is this fee affecting premiums currently and in the future?

AHIP Response: The ACA's tax on health insurance has increased the cost of coverage for consumers. An analysis by the actuarial firm Oliver Wyman estimated that the tax would increase premiums by 2.1 percent on average in 2014. Since the amount the tax is required to collect increases over time, premiums in 2023 are estimated to be, on average, 3.25 percent higher than they would be without the tax. The full analysis by Oliver Wyman is available at http://ahip.org/Issues/Documents/2011/Oliver-Wyman-Study--Estimated-Premium-Impacts-of-Annual-Fees-Assessed-on-Health-Insurance-Plans.aspx.

A subsequent analysis, also by Oliver Wyman, estimated the state-by-state impact of this tax, and is available at http://www.ahip.org/WymanState.

b. How is this fee affecting the decision to participate in the marketplace?

AHIP Response: Prior to the passage of the ACA, the Congressional Budget Office noted that the law's health insurance tax would be "largely passed through to consumers in the form of higher premiums for private coverage" (CBO Letter to Sen. Bayh, November 30, 2009). This tax, along with other taxes and fees associated with providing health insurance, increases the cost of coverage and makes coverage less affordable—particularly for small businesses and individuals purchasing coverage in the exchange.

Questions From the Honorable Pete Olson:

1. In your experience, has CMS built the operation function to pay health plans participating in the Federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?

AHIP Response: Yes, it is our understanding that the current manual processes are working. On a monthly basis, health insurers are submitting enrollment and other data so that CMS may provide premium and cost-sharing subsidies to insurers. As part of this process, if there was a change in enrollment, in addition to submitting information about the current month, health insurers are also making adjustments to past months (e.g., in the case of an incorrect enrollment or retroactive termination). We understand that CMS is in the process of building the fully automated process under which CMS would be providing this information directly to health insurers.

2. Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?

AHIP Response: On a monthly basis, health insurers provide CMS with information related to enrollment and total premium which is used by CMS to calculate the FFM user

fee which are netted against subsidy payments to insurers. We are unaware of what happens once these fees are collected.

3. Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?

AHIP Response: We are aware that for the individual market, the outstanding 834 transactions involve the 834 maintenance transaction which is used to report changes to demographic information (name, address, phone number) and report changes due to a special enrollment period (change in APTC, new plan, etc.). To support these types of changes without the full transaction, CMS has implemented the temporary Change in Circumstance (CIC) functionality which requires manual work by health insurers in order to process.

In addition, the process of submitting 834 files for enrollment reconciliation has not yet been implemented. An interim process will begin in July of 2014. We are unaware of the reason for the delay.

All 834 transactions related to the SHOP marketplace were deferred for 2014, and will be implemented for the 2015 plan year due to the delay of direct enrollment for the SHOP. In 2014 eligible employers can enroll directly with the health insurance plan.

Questions From the Honorable Morgan Griffith:

1. One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians – particularly specialists – are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice – give up their specialist or pay the high cost sharing required for out-of-network physicians.

   a. What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?

   AHIP Response: Similar to last year, health plans are required to make their provider directories available to the Marketplace for publication online by providing the URL link to their network directory. CMS expects the URL link to direct consumers to an up-to-date provider directory where the consumer can view the provider network that is specific to a given QHP. This is where all potential enrollees must go prior to enrollment to verify that their providers/specialists are part of the health plan's provider network before enrolling. This year, new guidance requires the URL provided to the Marketplace to link directly to the directory, such that consumers do not have to log on, enter a

policy number, or otherwise navigate the issuer's website before locating the directory.

b. What kind of information about provider networks will be available to help them choose a plan?

AHIP Response: Regulations and CMS guidance require health plan provider directories to include location, contact information, specialty, medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. CMS encourages issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider.

c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

AHIP Response: In addition to the information above, we want to make clear that health plans work every day to ensure their provider directories are accurate and up-to-date. Thus it is very important for existing enrollees to review their health plan's provider directory during open enrollment and if their providers are not available, to make a change to another qualified health plan available in their area.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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June 27, 2014

Mr. Frank Coyne
Vice President of Operations
Chief Transformation Officer
Blue Cross Blue Shield Association
1310 G Street, N.W.
Washington, D.C. 20005

Dear Mr. Coyne:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 7, 2014, to testify at the hearing entitled "PPACA Enrollment and the Insurance Industry."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Friday, July 11, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

August 4, 2014

The Honorable Tim Murphy
Chairman
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

Thank you for your June 27, 2014 letter. The information you have requested is attached.

Sincerely,

Alissa Fox

Alissa Fox
Senior Vice President
Blue Cross Blue Shield Association

The Honorable Marsha Blackburn

1. How many insurance policies has Blue Cross Blue Shield sold in Tennessee via the federal exchange? How many did the Tennessee Blue sell in 2012 and 2013?

As of today, we have sold 120,121 policies through the Federally Facilitated Marketplace (FFM). This includes any policies that have since cancelled/terminated after being effectuated.

According to our internal Direct Markets Sales Report, the number of policies sold in our Individual under 65 line of business for the two prior years is as follows:

- 2013 – 20,644
- 2012 – 18,143

2. What difficulties has Blue Cross Blue Shield experienced with the implementation of the health care law? What difficulties do you expect in the future?

Like other health plans, we have experienced issues with accuracy and completeness of data transmitted from the Federally Facilitated Marketplace. We have worked closely with federal officials and consumers to make sure we have the correct information in enrolling new members through the Marketplace. The Administration continues to finalize the "back-end" functionality of HealthCare.gov, and health plans are doing a significant amount of the work manually. Our number one goal is for our customers to have a good experience, and Blue Plans will continue to work around the clock to help consumers navigate the new system.

The Honorable Michael C. Burgess

1. While some of the basic problems with the front-end components that individuals face on HealthCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.

a. **Have any significant improvements been made to these components?**

There is still significant amount of work needed on the back-end and Plans are doing a much of the work manually. This includes:

- Payment systems: the 820 electronic payment transaction still must be put in place, so in the interim, Plans are submitting excel spreadsheets;
- Enrollment reconciliation; and

- Processing life event changes such as the birth of a child or getting married.

b. **How will these continued problems affect plan participation and premiums for 2015?**

Our number one goal is for consumers to have a good experience and get enrolled in the Plan of their choice. We will continue to work to ensure consumers have access to affordable, high quality health coverage.

2. 834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.

a. **Has this been your experience?**

b. What is your estimation of the failure rate?

c. Has the failure rate improved over time and by how much?

d. What problems has this caused for your companies, your enrollees, and contracted providers?

BCBSA is not an issuer and does not have a system to capture 834 transmissions; therefore we do not have the information necessary to answer these questions

3. Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.

a. Do you have an estimation of the number of duplicate enrollments in your system?

No, this is not something we track.

b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

We do not know the methodology the administration used in calculating enrollment numbers.

4. The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is

terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.

a. I f enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?

BCBSA is not a health insurance company and does not pay provider claims. However, we note that while the CMS Exchange Final Rule issued in 2012 allows issuers to pend claims during the second and third month of the ACA's 3 month grace period, issuers are required under the regulation to retroactively terminate coverage to the end of the first month of the grace period if an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period without paying all outstanding premiums. Specifically, Section 156.270(g) says "the QHP issuer must terminate the enrollee's coverage on the effective date described in Section 155.430(d)(4)," which is "the last day of the first month of the 3-month grace period."

b. If you do not pay the claims, who will make providers whole?

In general, state grace period requirements preceded enactment of the ACA's 3-month grace period. Under these requirements, issuers, providers and consumers follow established policies which typically address instances when individuals incur claims from a provider and that individual is not a covered member in a health plan. BCBSA is not a health insurance company and does not pay provider claims.

c. Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?

No, BCBSA is not a health insurance company and does not write health insurance plans or policies.

d. Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.

No, we do not have the data to answer this question.

5. One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.

a. Do you know how many enrollees are currently covered but behind on paying their premiums?

No, BCBSA does not collect this data.

b. The law says that you must provide this information to HHS. Are you doing so?

No, BCBSA is not a health insurance company, therefore does not collect this data.

c. What is the process for communicating with providers when enrollees enter a grace period?

As Plans implement requirements for the ACA's three month grace period, Plans continue to use the communication methods that work best with providers in their local markets. BCBSA does not collect the methodologies Plans use to communicate with their providers.

6. Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.

a. Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?

b. Please describe the process if there is a process in place.

c. If there is a process, have any miscalculated payments been reconciled?

d. If miscalculated payments have been reconciled, how many have been processed?

e. Please provide an estimation for the administrative cost of these miscalculations if possible.

f. How might the miscalculation of payments affect plans for next year in terms of participation or premiums?

Based on the recent HHS Office of the Inspector General report on inconsistencies, while over one million new enrollees are currently in the inconsistency period, it does not "necessarily indicate that an applicant provided inaccurate information or is enrolled in a QHP or is receiving financial assistance through insurance affordability programs inappropriately." Since the beginning of the year, issuers have received monthly payments for subsidized enrollees from CMS through an interim payment process based on

aggregated payment data. CMS has indicated that later this year, issuers and CMS will transition to a member-level payment process and reconcile all payments previously made under the interim process. CMS has not published specific details of the transition or reconciliation process, and thus BCBSA does not have any estimates of the administrative costs associated with the transition or reconciliation.

The Honorable Pete Olson

1. In your experience, has CMS built the operation function to pay health plans participating in the Federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?

Since the beginning of the year, issuers have received monthly payments for subsidized enrollees from CMS through an interim payment process based on aggregated payment data. CMS has indicated that later this year, issuers and CMS will transition to a member-level payment process and reconcile all payments previously made under the interim process. CMS has not published specific details of the transition or reconciliation process.

2. Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?

For the Federally Facilitated Marketplace that is run primarily by the federal government (which includes 32 states including the Partnership states), the federal government user fee will apply to insurers in order to help the funding of the marketplace. Currently, user fees charged by the federal government cover the majority of costs related to the continued operation of federally facilitated marketplace. For example in FY 2015, user fees will fund 66% of the operating cost for the federal marketplace. http://cms.hhs.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf (see page 31) These user fees will support activities such as the enrollment, consumer outreach, education and assistance activities that health plans currently pay themselves. Marketplaces are required by the ACA to be self-sustaining on January 1, 2015.

3. Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?

BCBSA is not an issuer and does not have a system to capture 834 transmissions; therefore we do not have the information necessary to answer these questions

<u>The Honorable Morgan Griffith</u>

1. One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians- particularly specialists- are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice- give up their specialist or pay the high cost sharing required for out-of-network physicians.

a. What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?

We would advise encouraging consumers to make use of the searchable, web-based provider directory tools that health plans make available to determine which specialists participate. If the consumer has trouble finding or using the tool, he or she should call the Plan's customer service line.

b. What kind of information about provider networks will be available to help them choose a plan?

As independent companies, Blue Plans all provide searchable web-based directories to help consumers find providers by name or by type within a geographic region (e.g., all in-network cardiologists by county, or within a 5 mile radius of a zip code). The directories typically include information about the provider's accessibility and quality. For hospitals, the directory will likely indicate whether it's a Blue Distinction Facility (a hospital recognized on the basis of extensive criteria developed with medical specialty societies – such as the track record for procedure results -- as having proven expertise in delivering that specialty care), and overall patient reviews on a five-star scale; for physicians, the directory will likely show not only basics such as board certification, accepting new patients, uses e-prescribing, wheelchair accessible, but also various quality metrics such as the "Blue Recognition Program" (primary care physicians who are active in a national, regional, and/or local quality improvement and/or recognition program), clinical quality measures (e.g., breast cancer screening rates), and patient ratings.

c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

Every year Blue Plans update and enhance the quality information available about in-network providers, and strive to maintain the accuracy of their directories. As accredited organizations, qualified health plans must meet specific standards. For example, NCQA requires that plans' physician and hospital directories contain the most current information, that plans test the directory for understanding and member ease of use, and make the directory available in other formats (e.g., printed, by telephone) for those who do not want to or cannot search a web-based directory.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

June 27, 2014

Mr. Paul Wingle
Executive Director
Individual Business & Public Exchange Operations and Strategy
Aetna
151 Farmington Avenue
Hartford, CT 06156

Dear Mr. Wingle:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 7, 2014, to testify at the hearing entitled "PPACA Enrollment and the Insurance Industry."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, July 11, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Akin Gump
STRAUSS HAUER & FELD LLP

STEVEN R. ROSS
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September 8, 2014

VIA HAND DELIVERY

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy:

On behalf of Aetna Inc. ("Aetna" or "the Company"), we write in response to your June 27, 2014 letter (the "Letter") containing questions for the record and additional information requests made in connection with the Subcommittee's May 7, 2014 hearing, "PPACA Enrollment and the Insurance Industry." As discussed with Committee staff, today's submission addresses many of the questions posed by the Members of the Committee in your Letter. As additionally discussed with Committee staff, Aetna looks forward to meeting with staff to further discuss the balance of these questions. Please note that today's submission includes relevant information for all Aetna subsidiaries, including entities acquired through Aetna's acquisition of Coventry Health Care, Inc., and also for Innovation Health, a joint venture between Aetna and Inova Health System. As requested, and for the questions and subparts addressed in this submission, we have provided the information below in a format consistent with the Subcommittee's letter. Please note, as outlined below, that certain of the information provided in this submission is proprietary in nature, and we respectfully request that it be treated accordingly.

* * *

The Honorable Michael C. Burgess

1. While some of the basic problems with the front-end components that individuals face on HealthCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.

a. Have any significant improvements been made to these components?

Aetna's experience with the implementation of the Federally Facilitated Marketplace ("FFM") has been generally consistent with the well-publicized issues identified during the 2014 Open Enrollment. Some improvements have been made but more are needed. Aetna's experience is that the back-end, operational components of the FFM are not yet complete. Specifically, there are gaps in the FFM's Eligibility and Enrollment Module, and the FFM's Financial Management Module remains incomplete. For example, carriers send 834 termination transactions to the FFM, but it is unclear if they are processing them.

Ensuring that the FFM back-end is fully automated remains a key concern. Aetna continues to work with CMS, as appropriate, to address issues caused by these technical problems and to mitigate potential disruption to consumers.

b. How will these continued problems affect plan participation and premiums for 2015?

Aetna uses several criteria to make decisions about participating in the public exchanges, including its ability to offer competitive products and services, projected medical cost experience with the population, and risks and uncertainties associated the regulatory and operational environment. For 2015, Aetna's public exchange footprint is likely to be similar to 2014 (to also include Georgia), but the Company's participation on any public exchange is not final until its filings—which include products, networks, and rates—are approved and Aetna chooses to sign the final participation agreement.

2. 834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.

a. Has this been your experience?

Consistent with CMS guidance, Aetna reviews CMS-provided data to (1) remove duplicate records and (2) identify data inconsistencies on enrollment files for new members transmitted by the FFM. It is the Company's experience that 834 transmission issues which would cause an enrollment failure are typically resolved by working with CMS.

b. What is your estimation of the failure rate?

Please see Aetna's response to Question 2a above.

c. Has the failure rate improved over time and by how much?

Please see Aetna's response to Question 2a above.

d. What problems has this caused for your companies, your enrollees, and contracted providers?

As noted above in the response to Question 1a, ensuring that the FFM back-end is fully automated remains a key concern for Aetna moving forward. The lack of back-end automation is among the well-publicized issues that led to the ACA's roll-out problems and many accounts of consumer frustration.

Aetna remains concerned that reconciliation of appropriate data between plans and CMS is not occurring properly and is leading to confusion between plans, beneficiaries, and CMS in certain instances. For example, when Aetna terminates coverage for lack of premium payment (after significant customer outreach and notification), it sends notice of termination records to CMS—but it is unclear if they are processing them. As a result, Aetna's experience is that CMS' records may indicate that those members continue to have coverage even though Aetna's records accurately reflect cancellation of that coverage due to non-payment. Therefore, those members may receive conflicting information about their coverage status if they contact both CMS and Aetna. Aetna has raised this issue with CMS and requested improvements to their system to address this problem.

Aetna does not retain federal subsidy payments for customers for the months in which their coverage has been terminated. As appropriate, Aetna will continue to offer feedback to CMS and Congress to help resolve operational issues and to mitigate the potential disruption to beneficiaries and employers.

3. Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.

a. Do you have an estimation of the number of duplicate enrollments in your system?

As described in Aetna's response to Question 2a above, consistent with CMS guidance, the Company reviews CMS-provided data to remove duplicate records before they are applied to its system. Aetna does not track the number of duplicate enrollments that have been sent by CMS and, therefore, does not have sufficient information to answer this question.

b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

Aetna does not have sufficient information to answer this question.

4. The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.

a. If enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?

Consistent with applicable regulations and regulatory guidance, Aetna administers policies within the ninety-day "grace period" to minimize potential risks to providers. It is common practice for providers to verify the member's coverage before the member receives care. Providers typically reach out to Aetna in any of three standard ways—through a web-based eligibility confirmation tool, by phone call, or by a fax inquiry. If a provider asks through any of those channels about a member whose policy is in the grace period, Aetna will so inform the provider, who then has notice that the member may end up without coverage for services performed during the second and third months of the grace period.

Aetna updates the above data sources on a daily basis to ensure that providers have access to current information about the member's coverage status. Aetna makes payments for claims incurred during a grace period in accordance with regulatory guidance. The Company pays claims in line with the member's plan during the first month of the grace period and then holds, or "pends," claims that it receives during the second or third months of a grace period. Aetna does not pay those claims unless and until the subscriber becomes current on premium payments.

b. If you do not pay the claims, who will make providers whole?

Please see Aetna's response to Question 4a above. In addition, it is important to underscore that providers have access to information—on a daily basis—that would allow them to determine if a patient has paid his or her premium.

c. Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?

No. Please see Aetna's response to Question 4a above.

5. One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.

b. The law says that you must provide this information to HHS. Are you doing so?

Yes. Aetna reports delinquency status data to HHS on a daily basis.

c. What is the process for communicating with providers when enrollees enter a grace period?

Please see Aetna's response to Question 4a above.

6. Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.

a. Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?

Aetna follows relevant processes that CMS has implemented with respect to Exchange customer enrollment and subsidy information. Aetna does not have information that would allow it to independently determine the accuracy of premium subsidies. Aetna applies the subsidy amounts that CMS transmits to the Company in the 834 files. CMS may change those amounts from month to month for various reasons, including changes in an enrollee's income. When CMS makes such a change, they are sent to Aetna on an 834 file, and Aetna applies the change. CMS is the sole source of the relevant data and does not provide Aetna with information that would permit the Company to determine why a subsidy amount changed. Aetna does not retain federal subsidy payments for customers in the months where their coverage is no longer in effect.

b. Please describe the process if there is a process in place.

Please see Aetna's response to Question 6a above.

c. If there is a process, have any miscalculated payments been reconciled?

Please see Aetna's response to Question 6a above.

d. If miscalculated payments have been reconciled, how many have been processed?

Please see Aetna's response to Question 6a above.

e. Please provide an estimation for the administrative cost of these miscalculations if possible.

Aetna does not separately track the administrative costs related to the handling of APTC changes.

f. How might the miscalculation of payments affect plans for next year in terms of participation or premiums?

Please see Aetna's response to Question 1B above.

7. If a provider calls your company for information on the health care law, what resources or information is your company able to provide?

Aetna has dedicated provider service centers with trained representatives who can answer questions from providers on the Affordable Care Act and other issues. Aetna also has built websites (including, e.g., http://www.aetna.com/health-reform-connection/reform-explained/) that provide information for providers and consumers regarding the ACA.

9. How many plans has your company sold off-exchange in 2014? Provide this information for each state in which you sell.

Please note that Aetna previously provided this information in a confidential submission to the Committee on June 25, 2014. This submission included such off-exchange information as of the end of the day on May 20, 2014.

The Honorable Pete Olson

1. In your experience, has CMS built the operation function to pay health plans participating in the federally facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?

Aetna is currently using the interim payment process designed by CMS. CMS' final interim payment process has not yet been implemented.

2. Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?

No, Aetna is not aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee.

3. Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?

Aetna has no insight into CMS' outstanding 834 transactions. The company receives 834 files from CMS on a daily basis, and processes all transactions accordingly.

The Honorable Morgan Griffith

1. One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians - particularly specialists - are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice - give up their specialist or pay the high cost sharing required for out-of-network physicians.

a. What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?

Aetna's dedicated customer service centers are available to help your constituents and Aetna's customers understand their desired plan's network coverage. The Company has also developed online sites specific to its exchange networks to help current and prospective customers understand which providers are part of the exchange network in their area. Examples of these sites can be viewed at: http://www.aetna.com/dse/search?site_id=QualifiedHealthPlanDoctors and http://fl.coventryproviders.com. The Company continues to work to enhance its provider directory search capabilities for ease of use by members.

b. What kind of information about provider networks will be available to help them choose a plan?

Please see Aetna's response to Question 1a above.

c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

Please see Aetna's response to Question 1a above.

The Honorable Tim Murphy

1. Provide information on the number of plans your organization has sold in the Federally Facilitated Marketplace.

Please note that Aetna previously provided this information in a confidential submission to the Committee on May 29, 2014. This submission included such enrollment information as of the end of the day on May 20, 2014.

* * *

Please note, as indicated above, that certain of the information provided in this submission is proprietary in nature, and we respectfully request that it be treated accordingly. Additionally, please note that certain of the responses included in today's submission refer to information that Aetna has previously provided in separate, confidential submissions to the Committee. As discussed with Committee staff, by referring to such information above, it is not Aetna's intention to incorporate it, by reference or otherwise, into today's submission, and we respectfully ask the Committee to preserve the confidentiality of this information. Moreover, we respectfully renew our request that Committee staff provide us with notice and an opportunity to be heard before the Committee discloses to third parties any such information, notwithstanding our requests to the contrary, contained in any previous confidential submissions. If the Committee intends to make any such information that we previously provided in connection with this inquiry public in any way, we respectfully request that all information be aggregated and de-identified. Further, should the Committee make any such information public in any way, we respectfully request that the information being provided be disclosed together with all accompanying legends, footnotes, and disclaimers, in order to avoid potential confusion over the comparability of the information provided, and any other information that Aetna may publicly disclose or other measures Aetna may disclose that may—in the absence of such clarifying notes—appear similar despite important differences in the basis of preparation. Our provision of the enclosed information is not intended to constitute a waiver of the attorney-client, attorney work product, or any other applicable rights or privileges, in this or any other forum, and Aetna expressly reserves its rights in this regard.

Please let me know if you have any questions.

[redacted]

Steven R. Ross
Counsel for Aetna Inc.

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Minority (202) 225-3641

June 27, 2014

Mr. Brian Evanko
President, Individual Segment
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, CT 06002

Dear Mr. Evanko:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 7, 2014, to testify at the hearing entitled "PPACA Enrollment and the Insurance Industry."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, July 11, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

RESPONSES OF BRIAN EVANKO
PRESIDENT, U.S. INDIVIDUAL SEGMENT
CIGNA CORPORATION

HEARING BEFORE THE HOUSE ENERGY & COMMERCE COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
"PPACA ENROLLMENT AND THE INSURANCE INDUSTRY"

Attachment 1:
Additional Requests for the Record

The Honorable Michael C. Burgess

1. **While some of the basic problems with the front-end components that individuals face on HeathCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.**

   1.a. Have any significant improvements been made to these components?

   Response: Cigna does not have first-hand knowledge of what improvements CMS has made to the front-end components of HealthCare.gov. With regard to the back-end components, there are still processes that are in interim status or not yet developed. Other back-end systems have experienced improvement. For example, the quality of the 834 enrollment transactions improved over the course of open enrollment. CMS also improved its ability to electronically accept and communicate changes to existing policies (e.g., changes due to life events). Moreover, an interim enrollment reconciliation process completed testing in June and will be used to reconcile enrollment data between insurers and CMS. Cigna believes that these improvements must continue in order for the marketplace to function effectively.

   1.b. How will these continued problems affect plan participation and premiums for 2015?

   Response: Among other issues, many of the back-end processes, including the interim reconciliation process, remain largely manual, which is more burdensome and slower than a fully automated process. Issues regarding back-end processing were a factor in our assessment of whether to expand our participation on the Exchanges for 2015. These issues, however, have not had a material impact on premiums. Despite the ongoing issues with the back-end systems, Cigna will continue to work with CMS and other regulatory authorities to reduce the burden on Cigna customers and to help ensure access to Cigna's health insurance products.

2. **834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.**

2.a. Has this been your experience?

Response: The table below provides the percentage of 834 enrollment transactions sent to Cigna for new enrollees in the Federally Facilitated Marketplace that were defective. A transaction was considered defective if errors were present that prevented the transaction from being received and fully processed by Cigna. The figures in the table below reflect the best information currently available to Cigna from other sources and show that the percentage of defective 834 enrollment transactions has generally decreased over time.

October 2013	November 2013	December 2013	January 2014	February 2014	March 2014	April 2014	May 2014
REDACTED							

2.b. What is your estimation of the failure rate?

Response: Please see our response to Question 2.a.

2.c. Has the failure rate improved over time and by how much?

Response: Please see our response to Question 2.a.

2.d. What problems has this caused for your companies, your enrollees, and contracted providers?

Response: Defective 834 enrollment transactions may cause a number of problems for enrollees. For example, errors in the 834 enrollment transactions may prevent or delay the effectuation of an insurance policy and/or slow the reconciliation of subsidy payments. Additionally, flawed data can create a situation where family members (e.g., spouses and/or dependents) are incorrectly not included on a health insurance policy.

3. **Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.**

3.a. Do you have an estimation of the number of duplicate enrollments in your system?

Response: Cigna has received approximately 3,000 duplicate enrollments.

3.b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

Response: I do not know how the Administration calculated its enrollment figures.

4. The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.

4.a. If enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?

Response: In accordance with applicable regulations, Cigna will pay claims for the first 30 days of the grace period. Additional claims may be paid if the customer becomes current on his or her premium payments. Cigna would not be a part of any further payment arrangements between a provider and a patient.

4.b. If you do not pay the claims, who will make providers whole?

Response: Please see our response to Question 4.a.

4.c. Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?

Response: Please see our response to Question 4.a.

4.d. Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.

Response: Please see Cigna's May 29, 2014 production to the Committee, in which it provided data (current as of May 20, 2014) regarding the number of plans in the second and third month of the grace period.[1]

[1] Letter from Michael D. Bopp to The Honorable Fred Upton, The Honorable Tim Murphy, The Honorable Joseph R. Pitts, The Honorable Michael C. Burgess, The Honorable Joe Barton, and The Honorable Marsha Blackburn (May 29, 2014).

5. **One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.**

   5.a. **Do you know how many enrollees are currently covered but behind on paying their premiums?**

   Response: Please see Cigna's May 29, 2014 production to the Committee, in which it provided data (current as of May 20, 2014) regarding the number of plans in the second and third month of the grace period.[2]

   5.b. **The law says that you must provide this information to HHS. Are you doing so?**

   Response: Cigna provides regular reports to CMS in compliance with applicable laws and regulations. These reports include information to help CMS limit subsidy payments to enrollees who are eligible.

   5.c. **What is the process for communicating with providers when enrollees enter a grace period?**

   Response: Cigna has developed telephonic and online enrollment verification systems to make it easy for providers to determine enrollee eligibility. Additionally, Cigna has online resources related to PPACA that are available to everyone, including providers (*see, e.g.*, http://www.cigna.com/health-care-reform/).

6. **Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.**

   6.a. **Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?**

   Response: As an insurer, Cigna receives the amount of the premium subsidy as determined by CMS on the 834 enrollment file and/or pre-audit file. Cigna is not a party to the enrollment process through which income and other data is collected and that is necessary to calculate the premium subsidy for each individual or household. Insurers offering plans on HealthCare.gov are under an

[2] Letter from Michael D. Bopp to The Honorable Fred Upton, The Honorable Tim Murphy, The Honorable Joseph R. Pitts, The Honorable Michael C. Burgess, The Honorable Joe Barton, and The Honorable Marsha Blackburn (May 29, 2014).

obligation as part of the Qualified Health Plan contract with CMS to bill the amount of the tax subsidy communicated to the insurer by CMS. Insurance companies, including Cigna, would be unable to determine if the amount of the premium subsidy communicated via the CMS enrollment file is correct or incorrect. Ultimately, Cigna must rely on the information received from CMS regarding subsidy eligibility and the amount of any subsidy provided to an enrollee.

It is Cigna's understanding that the reconciliation process to determine if an individual or household received too little or too much of a premium subsidy will involve comparing the individual's 2014 reported income information from their tax return with the amount of the premium subsidy from the Exchange as part of the tax filing process. It is also Cigna's understanding that any over- or underpayments of the premium subsidy would be collected or paid via the tax filing process.

6.b. Please describe the process if there is a process in place.

Response: Please see our response to Question 6.a.

6.c. If there is a process, have any miscalculated payments been reconciled?

Response: If any reconciliation has taken place Cigna, as an insurer, would not be informed. Cigna must rely upon the information provided by CMS. If enrollment information (including subsidy information) changes for an enrollee, Cigna would receive an updated enrollment transaction from CMS. However, premium subsidy amounts could be updated for a number of reasons, including individuals reporting updated income information. Accordingly, Cigna would be unable to determine if the cause of premium subsidy change was the updated information from the enrollee or a reconciliation due to "miscalculated payments."

6.d. If miscalculated payments have been reconciled, how many have been processed?

Response: Please see our response to Question 6.c.

6.e. Please provide an estimation for the administrative cost of these miscalculations if possible.

Response: Please see our response to Question 6.c.

6.f. How might the miscalculation or payments affect plans for next year in terms of participation or premiums?

Response: Please see our response to Question 6.c.

7. **If a provider calls your company for information on the health care law, what resources or information is your company able to provide?**

Response: If a provider is looking for general information on the health care law, we refer to them to our award-winning online resource "Informed on Reform," which is available at www.cigna.com/health-care-reform. Should a provider have specific questions about our plans and benefits, our customer service agents and health care professional experience teams are equipped to discuss plan designs, essential health benefits, and in-network and out-of-network reimbursements.

8. **How much has your company been paid to date in premium tax credits?**

Response: Cigna received approximately $60 million in Advance Premium Tax Credit payments from January 2014–June 2014.

9. **How many plans has your company sold off-exchange in 2014? Provide this information for each state in which you sell.**

Response: Please see Cigna's June 23, 2014 production to the Committee, in which it provided data (current as of June 16, 2104) regarding off-exchange enrollments.[3]

* * *

The Honorable Pete Olson

1. **In your experience, has CMS built the operation function to pay health plans participating in the federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?**

Response: Cigna has received subsidy payments from CMS and, hence, there is a process in place to make subsidy payments to health insurance providers participating in the Federally-Facilitated Marketplace. As to whether the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts are currently working, payments are being made. Cigna must rely on information from the government when reconciling subsidy payments.

[3] Letter from Michael D. Bopp to The Honorable Tim Murphy and The Honorable Diana DeGette (June 23, 2014).

2. **Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?**

Response: We are not a position to comment on how CMS accounts for the monies collected by the Federally-Facilitated Marketplace user fee.

3. **Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?**

Response: Based on our interpretation of what is meant by "outstanding 834 transactions," Cigna has observed that some 834 transmissions contain errors (e.g., inaccurate or incomplete information), and Cigna works with CMS and the enrollee to rectify those errors. In other instances, Cigna may receive an 834 transmission for an enrollee who opts not to effectuate his or her policy by paying the first month's premium.

* * *

The Honorable Cory Gardner

1. **How many plans offered by your company did you cancel or discontinue in 2013 because of the health care law? Provide this information by the number of plans in each state and the total for your company nationwide.**

Response: In 2013, 938 health insurance plans were cancelled for policy holders in Connecticut. To clarify my testimony on this point at the May 7, 2014 hearing, Cigna did not also cancel non-PPACA compliant health insurance plans in South Carolina. Instead, Cigna offered extensions to policy holders in South Carolina following the Administration's announcement regarding the ability to grandfather certain health plans through 2014 that would otherwise not be permitted under PPACA.

Additionally, due to the availability of guaranteed issue individual health insurance coverage through the Exchanges, various states, including Georgia and California, repealed their statutes that required Health Maintenance Organizations to offer conversion coverage for individuals who ceased to be eligible for coverage under a group health plan. As a result of these repeals, and the fact that these states now offer guaranteed issue individual policies, Cigna terminated the 150 conversion policies in California and seven conversion policies in Georgia.

Finally, 158,906 cancellation notices were sent to limited benefit plan policy holders in various states. These policies, which can no longer be sold due to certain provisions in PPACA, offered lower premium and coverage options for individuals.

2. **How many plans did your company offer early renewal to in 2013 so they could continue in 2014 that would have otherwise been cancelled, ended, or otherwise modified by the health care law? Provide this information by the number of plans in each state and the total for your company nationwide.**

Response: Cigna offered renewals in all states where it offered individual health insurance products, except for Connecticut. The chart below is based upon information currently available to Cigna and details the number of renewals for non-PPACA compliant plans offered in 2013. The total number of renewals offered nationwide was REDACTED

Arizona	California	Colorado	Florida	Georgia	North Carolina	South Carolina	Tennessee	Texas
REDACTED								

3. **Last year the President apologized for the plans cancelled by the health care law and offered a delay of the enforcing of the requirements that led to the cancellations. This delay has since been extended. How many plans do you currently offer that do not meet the law's requirements but you are continuing to offer as a result of this policy? Provide this information by the number of plans in each state and the total for your company nationwide.**

Response: Cigna no longer sells health insurance plans that are not PPACA compliant to new customers. The chart below is based upon information currently available to Cigna and details the number of non-PPACA compliant plans that were active for existing customers as of May 31, 2014. The total number of such plans nationwide was REDACTED

Arizona	California	Colorado	Florida	Georgia	North Carolina	South Carolina	Tennessee	Texas
REDACTED								

* * *

The Honorable Morgan Griffith

1. **One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians—particularly specialists—are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice—give up their specialist or pay the high cost sharing required for out-of-network physicians.**

   1.a. What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?

   Response: Cigna is not offering Exchange plans in Virginia. However, as a general matter, Cigna is constantly evaluating its provider networks to ensure customer affordability and quality. Moreover, Cigna is undertaking an effort to simplify and clarify its online provider directory to make it easier for consumers to find accurate information on which providers are in Cigna's networks.

   1.b. What kind of information about provider networks will be available to help them choose a plan?

   Response: Please see our response to Question 1.a.

   1.c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

   Response: Please see our response to Question 1.a.

* * *

Attachment 2:
Member Requests for the Record

The Honorable Tim Murphy

1. **Provide information on the number of plans your organization has sold in the Federally-Facilitated Marketplace.**

   Response: Please see Cigna's May 29, 2014 production to the Committee, in which it provided data (current as of May 20, 2014) regarding the number of Exchange plans Cigna has sold.[4]

2. **Provide any analysis conducted by your organization in 2012, 2013, or 2014 on the impact of the Patient Protection and Affordable Care Act on the premiums paid by consumers. Provide any other analysis conducted on deductibles, out of pocket costs, or the networks your company provides for plans sold on the Federally-Facilitated Marketplace or state exchanges.**

   Response: Please see Cigna's April 4, 2013 and May 13, 2013 productions to the Committee, in which it provided information related to the potential impact of PPACA on health insurance premiums.[5]

* * *

The Honorable Marsha Blackburn

1. **Submit to the Committee any analysis conducted by your organization or by another party for your organization on premiums for plans sold in the Federally-Facilitated Marketplace, state marketplaces, or off the federal or state exchanges in 2015.**

   Response: Cigna is aware of numerous organizations that have conducted analyses and published informative materials on potential premium changes in 2015 for health insurance plans sold on the Exchanges. For example, the American Academy of Actuaries published a document that details the potential "drivers" of premium changes

[4] Letter from Michael D. Bopp to The Honorable Fred Upton, The Honorable Tim Murphy, The Honorable Joseph R. Pitts, The Honorable Michael C. Burgess, The Honorable Joe Barton, and The Honorable Marsha Blackburn (May 29, 2014).

[5] Letter from Michael D. Bopp to The Honorable Fred Upton (April 4, 2013); Letter from Michael D. Bopp to The Honorable Fred Upton (May 13, 2013).

next year.[6] Similarly, America's Health Insurance Plans ("AHIP"), Avalere Health, and the Urban Institute recently published their analysis and findings related to potential premium changes.[7]

If you are looking for different or other information, please contact us and we will be glad to discuss your questions further.

* * *

The Honorable Michael C. Burgess

1. **Provide a list of individuals from your organization that have met with White House officials, including but not limited to the President, in 2014 to discuss the Patient Protection and Affordable Care Act. Include the date of the meeting, the location, and the individuals present at the meeting. Provide all documentation, including e-mail, relating to these meetings. This would include, but is not limited to, correspondence setting up the meeting, materials prepared in preparation for the meeting, materials distributed or obtained at each meeting, and materials prepared afterwards summarizing or discussing the meeting.**

Response: I am aware of three meetings attended by Cigna personnel and White House officials in 2014 during which topics related to the Patient Protection and Affordable Care Act were discussed. The first meeting, which concerned payment reform, occurred on January 14, 2014 in the White House complex. Cigna was represented by Dr. Alan Muney, Chief Medical Officer; Herbert Fritch, President of Cigna-HealthSpring (Cigna's Medicare Advantage company); and Kristin Julason Damato, Vice President, Public Policy & Federal Affairs. Among the other attendees were Chris Dawe, Health Policy Advisor to the National Economic Council and Timothy Gronniger, Senior Adviser for Health Care Policy, White House Domestic Policy Council.

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[6] American Academy of Actuaries, *Drivers of 2015 Health Insurance Premium Changes* (June 2014) (available at http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf).

[7] America's Health Insurance Plans, *What You Need to Know About 2015 Premiums* (June 25, 2014) (available at http://www.timeforaffordability.com/2015premiums/); Avalere Health, *Exchange Plan Renewals: Many Customers Face Sizeable Premium Increases in 2015 Unless They Switch Plans* (June 26, 2014) (available at http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1403791423_20140625_silver_market_disruption.pdf); Avalere Health, *Average Exchange Premiums Rise Modestly in 2015 and Variation Increases* (June 18, 2014) (available at http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1403119552_20140616_2014_Exchange_Rates_FINAL.pdf); Urban Institute, *Will Premiums Skyrocket in 2015?* (May 2014) (available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413410).

The second meeting, which concerned expatriate health plans, occurred on April 25, 2014 in the White House complex. Cigna was represented by David Cordani, President and CEO; Nicole Jones, General Counsel; Kristin Julason Damato, Vice President, Public Policy & Federal Affairs; and Neil Tanner, Chief Counsel. The meeting was also attended by Phil Schiliro, White House Advisor for Health Policy.

The third meeting, which was organized by the Business Roundtable, occurred on July 24, 2014 in the White House complex. Cigna was represented by Kristin Julason Damato, Vice President, Public Policy & Federal Affairs. Among the other attendees were Kristie Canegallo, White House Deputy Chief of Staff; Jeanne Lambrew, Deputy Assistant to the President for Health Policy; Tim Gronniger, Senior Advisor for Health Policy, White House Domestic Policy Council; Mark Iwry, Senior Advisor to the Secretary of the Treasury and Deputy Assistant Secretary, Treasury Department; and Dr. Meena Seshamani, Office of Health Reform, Department of Health and Human Services.

Cigna is reviewing whether it has documents responsive to this request.

* * *

The Honorable Morgan Griffith

1. **Provide a list of the states in which you will provide coverage on the federal or state exchange in 2015 and the date on which you will submit your 2015 premium rate filings. List the individuals in the federal or state government to which you will be submitting this information. Provide copies of those submissions to the Committee as they occur.**

Response: The table below identifies the states in which Cigna has submitted 2015 premium rates filings for exchange plans and the date on which those filings were made.

State	Date Submitted
AZ	5/1/2014
CO	6/6/2014
FL	6/16/2014
GA	6/13/2014
MD	5/1/2014
MO	6/20/2014
TN	6/9/2014
TX	6/24/2014

Rate filing information is available on some state agency websites, including:

- Arizona Department of Insurance (available at http://www.azinsurance.gov/RateReview/HFAIpage.html#);
- Colorado Department of Regulatory Agencies, Division of Insurance (available at https://www.dora.state.co.us/pls/real/external_forms.serff_link#);
- Florida Office of Insurance Regulation (available at https://apps8.fldfs.com/IFileExternalSearch); and
- Maryland Insurance Administration (available at http://www.healthrates.mdinsurance.state.md.us/).

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

June 27, 2014

Mr. J. Darren Rodgers
Senior Vice President and Chief Marketing Officer
Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601

Dear Mr. Rodgers:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 7, 2014, to testify at the hearing entitled "PPACA Enrollment and the Insurance Industry."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, July 11, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

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Oklahoma · Texas

J. Darren Rodgers
Chief Marketing Officer

CONFIDENTIAL TREATMENT REQUESTED
September 5, 2014

The Honorable Tim Murphy
Chairman
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy:

On behalf of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), I am submitting HCSC's response to your letter dated June 27, 2014 ("Letter") regarding additional questions submitted for the record by Members further to the May 7, 2014 hearing entitled "PPACA Enrollment and the Insurance Industry".

Background Information. HCSC is a non-profit, member-owned organization. The individuals and employers who are served by HCSC are the same people who sustain the company. We remain committed to the customer-owned non-publicly traded structure.

HCSC is headquartered in Chicago, Illinois with a workforce of nearly 20,000 employees in more than 73 offices. HCSC, as an independent licensee of the Blue Cross Blue Shield Association, currently provides Blue Cross Blue Shield coverage to nearly 14 million members through its divisions in Illinois ("BCBSIL"), Montana ("BCBSMT"), New Mexico ("BCBSNM"), Oklahoma ("BCBSOK") and Texas ("BCBSTX").

About this Submission. HCSC is voluntarily complying with the Committee's request as set forth below. This response was prepared to the best of our abilities in order to comply with the Committee's requests within the Committee's timeframe. Given that timeframe, and the extensive scope of HCSC's multistate business, HCSC could not conduct a comprehensive search of all information that could be potentially responsive, but instead focused on obtaining relevant information in the possession of those employees most likely to have information pertaining to the subject matter of this inquiry. We have made good faith interpretations regarding the scope of the requests, and we have specified them in our response.

Many of the questions contained in the Members' inquiries go beyond my knowledge and area of expertise. Accordingly, I have relied on staff in various parts of our company to supply data and information that responds to many of the inquiries.

Confidentiality. HCSC respectfully requests that all responsive information attributable to HCSC be treated as confidential. To the extent the Committee intends to publicly disclose any responsive information, HCSC further respectfully requests that the Committee do so in a

aggregate form. To the extent possible, we further request that the Committee notify our company in advance of any such disclosure so that appropriate communications and business measures may be put in place to protect our business.

Responsive Information

Attachment 1 – Additional Questions for the Record

The Honorable Michael C. Burgess

1. ***While some of the basic problems with the front-end components that individuals face on HealthCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.***

   a. ***Have any significant improvements been made to these components?***

From our experience, improvements are being gradually made and work is ongoing to address remaining problems that affect insurers. The sequencing of some of the improvements, although they may be "significant" in nature, may not have always coordinated with the timing of insurer needs.

   b. ***How will these continued problems affect plan participation and premiums for 2015?***

We do not know and we cannot speculate at this time as to if or how issues with the back-end systems will affect plan participation and premiums for 2015.

2. ***834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.***

   a. ***Has this been your experience?***
   b. ***What is your estimation of the failure rate?***
   c. ***Has the failure rate improved over time and by how much?***

We have experienced a number of difficulties in 834 transmissions, particularly due to CiC (Change in Circumstance) transactions. These difficulties have increased over time. While we are not sure what is specifically meant by "errors" or "failure rate" in your question, we believe the 30% figure above to be reasonably reflective of our experience on overall issues we have generally experienced to date with 834 transmissions.

   d. ***What problems has this caused for your companies, your enrollees, and contracted providers?***

We have experienced delays in enrolling members and delays in processing maintenance transactions (CiCs). We have significantly increased the number of employees needed to

manually process CiC transactions and to field more extensive calls than previously anticipated from our members.

3. ***Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.***

    a. ***Do you have an estimation of the number of duplicate enrollments in your systems?***

We have in place matching programs to prevent enrolling duplicates in our systems. However, we are still receiving duplicate enrollments from the Marketplace. Our estimate of the number of duplicate enrollments is approximately 5% at this time.

    b. ***Do you think the Administration has included duplicate enrollments in their enrollment totals?***

We do not have any information on which we can respond to this question as we do not know what is included in the Administration's figures.

4. ***The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.***

    a. ***If enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?***

During the grace period, we pay all appropriate claims rendered to the member during the first month of the grace period and we may pend certain claims for services rendered in the second and third month of the grace period. We also must notify HHS of such non-payment.

    b. ***If you do not pay the claims, who will make providers whole?***

The providers are notified of delinquent accounts at the time they make an eligibility and benefits inquiry and are notified that claims may not be paid as a result.

    c. ***Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?***

Yes.

    d. ***Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.***

As of August 1, 2014, we had approximately 68,500 policies in the three-month grace period.

5. ***One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.***

    a. ***Do you know how many enrollees are currently covered but behind on paying their premiums?***

As of August 1, 2014, we had approximately 68,500 policies in the three-month grace period. The three-month grace period is only applicable to those receiving a premium tax credit.

    b. ***The law says that you must provide this information to HHS. Are you doing so?***

Yes. We send Termination and Cancellation notices to CMS for non-payment.

    c. ***What is the process for communicating with providers when enrollees enter a grace period?***

We have several processes available to our providers for making inquiries including interactive voice response (IVR) and online systems.

6. ***Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.***

    a. ***Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?***

Yes. Adjustments are made to subsidies when an error is discovered and we receive an updated record from HHS and update internally.

    b. ***Please describe the process if there is a process in place.***

We file restated numbers each month reflecting any new values for January 2014 through the current reporting period. Any adjustments will retroactively be included in the resubmission for the applicable months. We receive (or return) the difference between what was received in prior months and the current restatement.

    c. ***If there is a process, have any miscalculated payments been reconciled?***

We have reported adjustments monthly in the form of resubmitted data at the Qualified Health Plan level.

    d. ***If miscalculated payments have been reconciled, how many have been processed?***

We do not track adjustments at the member level.

*e. **Please provide an estimation for the administrative cost of these miscalculations if possible.***

We do not track administrative costs related to this issue.

*f. **How might the miscalculation of payments affect plans for the next year in terms of participation or premiums?***

We do not track potential impact on participation or premiums.

*7. **If a provider calls your company for information on the health care law, what resources or information is your company able to provide?***

We have a wide variety of resources and informational materials on the health care law including online resources, educational materials, and knowledgeable customer service representatives.

*8. **How much has your company been paid to date in premium tax credits?***

Discussions with Committee staff regarding our response to this inquiry are ongoing at this time. Additionally, we would be happy to meet with Representative Burgess or his staff in person to discuss this question.

*9. **How many plans has your company sold off-exchange in 2014? Provide this information for each state in which you sell.***

Responsive information was previously provided to the Committee staff on July 1, 2014, with a request for confidential treatment. We respectfully reiterate our request for confidential treatment of this information, and ask that it not be disclosed publicly.

*10. **If people have not paid the first month's premium for their policy, then they are not actually covered even if they believe they are enrolled. There have been reports of Texas clinics being put on hold for hours by BlueCross BlueShield of Texas attempting to verify enrollment before they can actually treat patients with Exchange coverage.***

*a. **Have the numerous issues with HealthCare.gov contributed to this backlog?***

Yes, they have. Our experience has shown that calls from our members are heavier in volume and more complicated in nature as members are trying to understand the enrollment process and their options. It takes our highly trained representatives longer processing time to fully respond to each of our members' inquiries. We have significantly increased our staffing to accommodate all of our members as promptly as possible and regret any delays they may have experienced.

*b. **What is HCSC doing to ease this burden on providers?***

We have provided multiple avenues for provider inquiries including Interactive Voice Response (IVR) and online processes. We have made significant investments in customer service,

education and technology to address these issues including increased staffing and training protocols.

The Honorable Pete Olson

1. ***In your experience, has CMS built the operation function to pay health plans participating in the Federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?***

In our view, the systems are working and we anticipate will be on a path of continued improvement as the Marketplace evolves.

2. ***Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If so, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?***

We do not know how CMS manages the money related to user fees.

3. ***Last year the President apologized for the plans cancelled by the health care law and offered a delay of the enforcing of the requirement that led to the cancellations. This delay has since been extended. How many plans do you currently offer that do not meet the law's requirements but you are continuing to offer as a result of this policy? Provide this information by the number of plans in each state and the total for your company nationwide.***

For HCSC, only Illinois policies were impacted by this particular policy. We estimate around 63,000 policies in Illinois.

The Honorable Cory Gardner

1. ***How many plans offered by your company did you cancel or discontinue in 2013 because of the health care law? Provide this information by the number of plans in each state and the total for your company nationwide***

Discussions with Committee staff regarding our response to this inquiry as well as the following two inquiries are ongoing at this time.

2. ***How many plans did your company offer early renewal to in 2013 so they could continue in 2014 that would have otherwise been cancelled, ended, or otherwise modified by the health care law? Provide this information by the number of plans in each state and the total for your company nationwide.***

3. ***Last year the President apologized for the plans canceled by the health care law and offered a delay of the enforcing of the requirements that led to the cancellations. This***

delay has since been extended. How many plans do you currently offer that do not meet the law's requirements but you are continuing to offer as a result of this policy? Provide this information by the number of plans in each state and the total for your company nationwide.

The Honorable Morgan Griffith

1. ***One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians - particularly specialists – are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice – give up their specialist or pay the high cost sharing required for out-of-network physicians.***

a. ***What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?***

b. ***What kind of information about provider networks will be available to help them choose a plan?***

c. ***What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?***

When customers choose a new health insurance plan through the exchange, they are given information about the doctors and hospitals included in each plan offered. We make the network information accessible to purchasing members before they select our products so that they can make the choice that is right for them. HCSC's goal is to expand access to quality, cost-effective health care to as many people as possible in every part of the states in which we operate. We offer a variety of network configurations to provide our members the greatest choice while providing quality network choices and great service at different price points to meet their individual needs. We also have customer service representatives available to assist members should they have questions about a particular physician or hospital's participation in a network.

Attachment 2 – Member Requests for the Record

The Honorable Tim Murphy

1. ***Provide information on the number of plans your organization has sold in the Federally-Facilitated Marketplace.***

Responsive information was previously provided to the Committee staff on April 18, 2014, with a request for confidential treatment. We respectfully reiterate our request for confidential treatment of this information, and ask that it not be disclosed publicly.

2. ***Provide any analysis conducted by your organization in 2012, 2013 or 2014 on the impact of the Patient Protection and Affordable Care Act on the premiums paid by consumers. Provide any other analysis conducted on deductibles, out of pocket costs, or the networks your company provides for plans sold on the Federally-Facilitated Marketplace or state exchanges.***

The scope of this request involves proprietary and competitively sensitive information, as I explained at the May 7 hearing. Discussions with Committee staff regarding our concerns are ongoing at this time.

The Honorable Marsha Blackburn

1. ***Submit to the Committee any analysis conducted by your organization or by another party for your organization on premiums for plans sold in the Federally-Facilitated Marketplace, state marketplaces, or off the federal or state exchanges in 2015.***

The scope of this request involves proprietary and competitively sensitive information, as I explained at the May 7 hearing. Discussions with Committee staff regarding our concerns are ongoing at this time.

The Honorable Michael C. Burgess

1. ***Provide a list of individuals from your organization that have met with White House officials, including but not limited to the President, in 2014 to discuss the Patient Protection and Affordable Care Act. Include the date of the meeting, the location, and the individuals present at the meeting. Provide all documentation, including email, relating to these meetings. This would include, but is not limited to, correspondence setting up the meeting, materials prepared in preparation for the meeting, materials distributed or obtained at each meeting, and materials prepared afterwards summarizing or discussing the meeting.***

On April 17, 2014, our CEO Pat Hemingway-Hall attended a meeting at the White House with the President. As I explained at the May 7 hearing, I was not in attendance at that meeting. We

would, however, be happy to meet with Representative Burgess or his staff in person to discuss to the extent we can any particular issues he may have related to this topic.

The Honorable Morgan Griffith

1. ***Provide a list of the states in which you will provide coverage on the federal or state exchange in 2015 and the date on which you will submit your 2015 premium rate filings. List the individuals in the federal or state government to which you will be submitting this information. Provide copies of those submissions to the Committee as they occur.***

We will offer coverage on the federal or state exchange in 2015 in Illinois, Montana, New Mexico, Oklahoma and Texas. As the rate filings are highly proprietary and confidential, and because they are not yet finalized and approved, HCSC will produce the finalized filings as they are approved and become public.

If you have any questions about this response, please contact HCSC's counsel at McDermott Will & Emery, Steve Ryan and David Ransom, at 202-756-8333.

Sincerely,

J. Darren Rodgers
Senior Vice President and Chief Marketing Officer
On behalf of Health Care Service Corporation, a Mutual Legal Reserve Company

cc (w/enclosure): The Honorable Fred Upton, Chairman
The Honorable Henry A. Waxman, Ranking Member
The Honorable Diana DeGette, Ranking Member, subcommittee on Oversight and Investigations

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-2927
Minority (202) 225-3641

June 27, 2014

Mr. Dennis Matheis
President of Central Region and Exchange Strategy
WellPoint, Inc.
120 Monument Circle
Indianapolis, IN 46204

Dear Mr. Matheis:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 7, 2014, to testify at the hearing entitled "PPACA Enrollment and the Insurance Industry."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, July 11, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

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August 29, 2014

BY E-MAIL AND U.S. MAIL

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

RE: Questions for the Record dated June 27, 2014

Dear Chairman Upton:

This letter comprises the second response of WellPoint, Inc. ("WellPoint" or the "Company") to the June 27, 2014 letter containing questions for the record regarding the testimony of Dennis Matheis before the Subcommittee on Oversight and Investigations on May 7, 2014 at the hearing titled "PPACA Enrollment and the Insurance Industry."

The Company has provided the enclosed responses, with information as of the date of the hearing unless otherwise noted, to the Member requests relating to the Committee's hearing and investigation regarding the Federally-Facilitated Marketplace (FFM). We will continue to confer with Committee staff regarding the remaining requests.

While the Company is responding to your inquiry voluntarily and is providing the enclosed information, the submission of this information does not waive, nor is it intended to waive, any rights, privileges, or immunities of WellPoint with respect to this matter, including any applicable attorney-client, work product, or other privilege or immunity. WellPoint expressly reserves all applicable privileges and immunities to which it is entitled under applicable law.

* * *

If you have any questions regarding this letter, please contact me at (202) 637-5493.

Sincerely,

[redacted]

E. Desmond Hogan
Counsel for WellPoint, Inc.
Partner
desmond.hogan@hoganlovells.com
D 202-637-5493

cc: The Honorable Diana DeGette
Ranking Member, Subcommittee on Oversight and Investigation

Questions for the Record for Dennis Matheis for WellPoint

Attachment 1- Additional Questions for the Record

The Honorable Michael C. Burgess

1. **While some of the basic problems with the front-end components that individuals face on HealthCare.gov have been addressed, numerous news sources continue to report that problems still plague the back-end systems that affect insurers.**

   a. **Have any significant improvements been made to these components?**

   While CMS is working to improve a number of issues that are impacting the functionality of Healthcare.gov, back end functionality is still being addressed. Two of the most pressing functionality issues are the 834 and 820 processes.

   834 Enrollment Data Reconciliation
   A permanent, automated 834 maintenance solution should be implemented to prevent divergence between issuer and FFM enrollment data. Doing so will improve data accuracy and allow plans to reallocate resources from continued manual processes to other critical functions.

   820 APTC/Premium Reconciliation
   CMS has yet to implement an automated 820 transaction system that issuers can use to reconcile the Advanced Premium Tax Credits (APTC) and Cost Sharing Reduction (CSR) subsidies. Until CMS implements an accurate 820 system, issuers and the FFM will continue to use a manual monthly Interim Payment Process. Any manual process is subject to higher error rates and will result in difficulties reconciling APTC and CSR payments at a subscriber/member level.

   b. **How will these continued problems affect plan participation and premiums for 2015?**

   In preparing 2015 premium rates, WellPoint subsidiaries have not taken into account the administrative costs incurred in working through issues arising from back-end systems whose functionality continues to be addressed. At some point if the challenges posed by the back-end systems are not addressed, WellPoint subsidiaries will need to evaluate whether increased administrative expenses will affect premium rates. The Company has reached no conclusion on what impact, if any, the back-end issues will have on plan participation in 2015.

2. **834 transmissions provide insurers with enrollment information for individuals from HealthCare.gov. It has been repeatedly reported that there are numerous errors in these transmissions with failure rates of over 30%.**

a. Has this been your experience?

b. What is your estimation of the failure rate?

c. Has the failure rate improved over time and by how much?

d. What problems has this caused for your companies, your enrollees, and contracted providers?

Response to 2(a)-(d):

WellPoint is unable to determine a failure or error rate for the 834 transmissions received from the Exchange. CMS – and not WellPoint – would have complete information on errors involving 834 transmissions. WellPoint can confirm, however, that it has experienced significant problems with the 834 transmission process. These errors in the 834 transmission process have created challenges for WellPoint staff and enrollees which WellPoint is working with CMS to overcome. For example, some customer abrasion issues have occurred when the customer believes they have submitted an application through the Exchange, but WellPoint has not received or is unable to process the application. In addition, delays in coverage for applicants can result when WellPoint must go back to the Exchange to request a corrected application file or where desired changes to a customer's plan were delayed due to 834 functionality issues. These and other issues with implementing the designed 834 functionality have resulted in increased manual work for WellPoint.

3. Due to problems with the 834 transmissions, there have been reports and witness testimony about a large number of duplicate enrollments.

a. Do you have an estimation of the number of duplicate enrollments in your system?

For the states in which WellPoint subsidiaries participate on the FFM (Georgia, Indiana, Maine, Missouri, New Hampshire, Ohio, Virginia, and Wisconsin), the FFM at times sent additional records as New Enrollments for the same applicants. Through the date of the hearing, these additional enrollments accounted for approximately 11% on average of the total submissions and terminations, not including voided enrollments requested by the Exchange.

b. Do you think the Administration has included duplicate enrollments in their enrollment totals?

WellPoint is not privy to the process and the data the Administration uses to calculate enrollment totals. WellPoint has no information on whether the Administration has or has not included duplicate enrollments in the enrollment totals it has reported. WellPoint has not included the additional records in its net enrollment numbers.

4. **The Obama Administration issued a final regulation in 2012 saying that enrollees would enter a 90-day grace period for non-payment of premiums before their coverage is terminated. The final rule stipulates that insurers only have to pay valid claims for the first 30 days of the 90-day grace period.**

    a. **If enrollees do not continue to pay their premiums and they enter a grace period, do you plan to pay providers for claims during the entirety of the grace period?**

In cases where the member has not paid their premium after the first month for on-exchange subsidy eligible products, the Company takes the following steps, as defined by regulations implementing the legislation:

- Process claims for services received during the first month. *See* 45 C.F.R. §156.270(d)(1) ("During the grace period, the QHP issuer must: Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period").
- Pend claims for services received during the second and third months of the grace period, until the full premium is received. Providers will receive a notification on their remittance indicating that the claim cannot be paid until the premium is received, and informing providers of the possibility of denied claims if the premium is not received by the end of the three month grace period. *See* 45 C.F.R. §156.270(d)(1) ("During the grace period, the QHP issuer . . . may pend claims for services rendered to the enrollee in the second and third months of the grace period"); 45 C.F.R. §156.270(d)(3) ("Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period").
- After the third month, if the member's premium is not received, the member's health plan will be terminated as provided in 45 C.F.R. §156.270(g), and the claims for services received during the second and third month will be denied. The member will be responsible for payment of services received during this time (up to charges). *See* 45 C.F.R. § 155.430 (d)(4) ("In the case of a termination [after the expiration of the 3-month grace period], the last day of coverage will be the last day of the first month of the 3-month grace period.").

    b. **If you do not pay the claims, who will make providers whole?**

The terms and conditions of the contract between WellPoint subsidiaries and providers apply to care rendered to "Covered Persons." When a policy or plan is terminated due to non-payment, the individual is no longer a Covered Person and the provider may bill the individual directly for services rendered.

    c. **Do you have a reconciliation process with providers for recouping payments made for claims incurred during a grace period?**

The Company does not have a recoupment process for claims incurred during the second and third months of the grace period for on-exchange subsidy eligible products because, as described above in response to question 4(a), provider claims for services during the second and third month of the grade period are not paid unless the member pays their premiums for those months. As required by 45 C.F.R. §156.270(d)(1), the Company processes claims incurred during the first month of the grace period regardless of whether the subscriber ultimately pays the premium for the first month of the grace period.

d. Do you have any data on the number of enrollees who fail to pay their premiums after the first month? If so, please provide this data.

WellPoint is unable to readily recreate historical data regarding the number of plans in the second or third month of the grace period as of the date of the Committee's hearing.

5. One of the major concerns raised about the implementation of the law is that individuals may stop paying their premiums at some point, enter a 90-day grace period and eventually their coverage will be canceled due to nonpayment.

a. Do you know how many enrollees are currently covered but behind on paying their premiums?

WellPoint is unable to readily recreate historical data regarding the number of plans in the second or third month of the grace period as of the date of the Committee's hearing.

b. The law says that you must provide this information to HHS. Are you doing so?

HHS has asked that this information be shared through the 834 reconciliation process and the Company will do so when that process is in place.

c. What is the process for communicating with providers when enrollees enter a grace period?

WellPoint subsidiaries value their relationships with contracted providers and strive to keep providers fully informed. Information regarding the grace period is available to providers through various channels. For example, state-specific information about health insurance exchanges and the grace period is available on the Provider Portal for each state in which WellPoint subsidiaries participate in the FFM: http://www.anthem.com/home-providers.html (The user must choose a state before going to that state's provider homepage and select "Health Insurance Exchange information".)

In particular, before providing a service to a subscriber of a WellPoint subsidiary, providers can electronically check whether the subscriber is in a grace period through the online eligibility and benefits process on the Provider Portal. The Company understands that many providers do check the patient's eligibility prior to the patient's visit as part of the provider's established office procedures. If a provider submits a claim for a subscriber in the grace period, the provider will receive a notification on their remittance indicating that the claim

cannot be paid until the premium is received, and informing providers of the possibility of denied claims if the premium is not received by the end of the three month grace period. *See* 45 C.F.R. §156.270(d)(1) ("During the grace period, the QHP issuer . . . may pend claims for services rendered to the enrollee in the second and third months of the grace period"); 45 C.F.R. §156.270(d)(3) ("Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period").

6. **Because of the significant back-end issues with HealthCare.gov, there is a strong possibility for inaccurate premium subsidies being paid to insurers from the federal government. The Washington Post recently reported that the federal government is likely providing inaccurate premium subsidies to more than one million new enrollees.**

   a. **Is there a reconciliation process in place to either recoup payments that were too low or return payments that were too high?**

   b. **Please describe the process if there is a process in place.**

   c. **If there is a process, have any miscalculated payments been reconciled?**

   d. **If miscalculated payments have been reconciled, how many have been processed?**

   Response to 6(a)-(d):

   The subsidy process begins when a consumer provides his or her income, family size, and additional demographic information during the application process through the Exchange. Based on the information provided by the consumer, the Exchange calculates the applicant's premium and any applicable APTC or CSR. The Exchange then provides the applicant's premium rate, APTC, and CSR to the Company in the 834 membership records. For CSR subsidized products, a per member per month ("pmpm") rate was filed and approved for each product. The Company works with the Exchange to ensure that the CSR amount is accurate for any given product, as the CSR subsidy rates applicable to a particular product contained in the 834 membership records are incorrect in some cases. The Company uses the APTC amount provided by the Exchange and any applicable CSR amount to reduce the premium amount to be collected from the subscriber. For states in which the Company participates in the FFM, the Company then submits the APTC information it received from the Exchange and the applicable CSR amount to CMS on a monthly basis and Treasury sends those funds to the Company through an Interim Payment Process ("IPP"). To date, the Company has not taken steps to attempt to reconcile the interim payments received from Treasury as CMS has described the payments as interim in nature and not final payments that would permit the Company to close its open receivables.

   Because the Company does not possess information on the consumer's income level or other demographic circumstances, the Company is unable to validate whether the APTC calculations it receives from the Exchange are accurate for any particular member. The

Company relies solely on the information received from CMS for all eligibility and subsidy related information. The Company does not communicate directly with our customers regarding income levels or other demographic circumstances. If any change occurs to a consumer's income or demographic information, it is the responsibility of the consumer to notify the Exchange, and for the Exchange to send the Company an updated 834 file with revised premium payment calculations. The Company understands that the IRS may recoup improper APTC or CSR payments from the consumer if a consumer submitted inaccurate income information to the Exchange.

e. Please provide an estimation for the administrative cost of these miscalculations if possible.

WellPoint has not calculated the total administrative costs attributable to updated 834 files received from Exchanges or the Interim Payment Process with CMS.

f. How might the miscalculation of payments affect plans for next year in terms of participation or premiums?

In preparing 2015 premium rates, WellPoint subsidiaries have not taken into account the administrative costs attributable to issues regarding membership reconciliation or premium subsidies. At some point if the challenges posed by these processes are not addressed, WellPoint subsidiaries will need to evaluate whether increased administrative expenses will affect premium rates. The Company has reached no conclusion on what impact, if any, these issues will have on plan participation in 2015.

7. If a provider calls your company for information on the health care law, what resources or information is your company able to provide?

WellPoint subsidiaries value the participation of providers in their networks and strive to keep providers fully informed about the ACA. If a provider contacts a WellPoint subsidiary with questions regarding the ACA, the Company can provide information regarding what the law allows related to a member's benefits and can answer general questions regarding the ACA. The Company can also direct the provider to external sources for additional information, such as a government website regarding the plan in which the member enrolled or to professional forums.

In addition, as described in the response to 5(c), providers can access the Company's provider portal for their state. The provider portal contains a wealth of communications and updates regarding state-specific information on health care reform. Providers may also access member-specific benefit and premium grace period information through the provider portal using the member's identification number. Providers may enroll in WellPoint's Network eUPDATE which notifies recipients of new updates regarding Exchanges and the ACA. Providers also receive a bi-monthly newsletter notifying them of relevant updates, changes, and information, including regarding the ACA. Newsletters are mailed to providers and stored on the provider portal for future reference.

The Honorable Pete Olson

1. **In your experience, has CMS built the operation function to pay health plans participating in the Federally Facilitated Marketplace? Specifically are the Advanced Premium Tax Credit and the Cost Sharing Reduction payment amounts currently working?**

   CMS has implemented a basic, interim solution under which the Company is receiving payments for the Advanced Premium Tax Credit (APTC) and the Cost Sharing Reduction (CSR). WellPoint remains concerned about operational and functionality issues relating to the APTC and CSR. WellPoint is working with CMS through the interim solution and looks forward to a final, fully-functioning solution.

2. **Are you aware of how CMS accounts for the monies collected by the Federally Facilitated Marketplace user fee? If yes, then in your experience how does the money generated by this fee used for the operation of the Federally Facilitated Marketplace?**

   WellPoint does not know how CMS accounts for the monies collected by the FFM user fee.

3. **Are there outstanding 834 transactions? If yes, has CMS offered any explanation as to why? And if they have explained, what does CMS attribute the delay to?**

   Currently, the Company cannot definitively determine whether any 834 transactions remain outstanding until CMS fully reconciles all enrollment information with the issuers. CMS has not provided a definitive date on the completion of any enrollment reconciliation efforts nor has CMS provided a timeline as to when they will be able to have a fully functional 834 process with enrollment file maintenance capabilities.

The Honorable Morgan Griffith

1. **One of the most troubling side-effects of Obamacare is happening across the country to patients who have found that their physicians — particularly specialists — are not part of their new health plan networks. During the open enrollment period for PPACA, individuals had limited information about whether their doctors were covered in a particular plan. Once enrolled, far too many of my constituents are faced with a difficult choice — give up their specialist or pay the high cost sharing required for out-of-network physicians.**

   a. **What can I tell my constituents to do in the next open enrollment period to determine which specialists are covered in their Exchange plans?**

   b. **What kind of information about provider networks will be available to help them choose a plan?**

c. What is your company doing to improve transparency about provider networks next year to make it easier for patients to keep access to their existing specialists?

Response to 1(a)-(c).

The Company is committed to providing information to individuals considering enrolling in a plan. The Company provides at least three ways for an individual to determine which specialists are covered in an Exchange plan. First, individuals can visit www.anthem.com to search the online provider directory using the "Find a Doctor" link to determine if a doctor, hospital or other health care provider is a participating provider in the network for the particular plan. Second, they can call the applicable member services toll-free number. A member services representative will assist them in determining which specialists are participating providers. In Virginia, that number is 1-855-748-1810. Third, they can request a paper copy of a provider directory by calling the member services toll-free number or by sending a written request to the applicable plan. In Virginia, the request would go to Anthem Blue Cross and Blue Shield, P.O. Box 27401, Richmond, Virginia, 23286-8708. The Company continually assesses cost, quality and access and makes adjustments to its provider networks as needed to meet and exceed customer expectations, while optimizing the value of our members' health care expenditures. When a provider exits the network, member services representatives are available to assist subscribers in locating a participating provider to suit their needs.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

2. Provide any analysis conducted by your organization in 2012, 2013, or 2014 on the impact of the Patient Protection and Affordable Care Act on the premiums paid by consumers. Provide any other analysis conducted on deductibles, out of pocket costs, or the networks your company provides for plans sold on the Federally-Facilitated Marketplace or state exchanges.

On April 1, 2013 and April 9, 2013, the Company provided confidential documents from 2013 referring to the intersection of the ACA and premium rates to the Committee. Since that time, the Company has not conducted any analysis specifically addressing the impact of the Affordable Care Act on premiums paid by consumers, deductibles, out of pocket costs, or provider networks.

The Honorable Marsha Blackburn

1. **Submit to the Committee any analysis conducted by your organization or by another party for your organization on premiums for plans sold in the Federally-Facilitated Marketplace, state marketplaces, or off the federal or state exchanges in 2015.**

   WellPoint subsidiaries consider a variety of factors in setting rates. Some of those factors include our 75 years' experience in the market, extensive market research among consumers, medical trend, the health insurance tax, our experience with provider networks, assumptions about the effects of regulatory or legislative change, and assumptions about enrollment demographics. The internal rate development process can take between 3 and 6 months. Then the Company begins the process of working with state and federal regulators to finalize and obtain approval of the rates. The various types of insurance offered by WellPoint subsidiaries are subject to a variety of state and federal regulations and oversight. The processes and timelines associated with these vary substantially, including the submission and filing approval dates and the notification windows for consumers. The Company will fully comply with all of the applicable state and federal regulations.

   Elizabeth Hall, WellPoint's Vice President of Federal Affairs, participated in a June 27, 2014 panel for the Alliance for Health Reform where she discussed WellPoint's rate setting process. A video of the panel discussion is available at http://www.c-span.org/video/?320195-1/health-insurance-premiums. Additionally, the McKinsey Center for U.S. Health System Reform prepared an analysis of 2015 Individual Exchange Filings as of July 5, 2014, available at http://healthcare.mckinsey.com/2015-individual-exchange-filings-0.

The Honorable Morgan Griffith

1. **Provide a list of the states in which you will provide coverage on the federal or state exchange in 2015 and the date on which you will submit your 2015 premium rate filings. List the individuals in the federal or state government to which you will be submitting this information. Provide copies of those submissions to the Committee as they occur.**

   The Company has filed rates in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin with the intent to participate on the FFM or SBM in 2015. In addition, though Missouri does not require issuers to file rates, the Company intends to participate on the Missouri exchange. However, until the Company signs Qualified Health Plan contracts for 2015, the Company maintains discretion to make a final determination on whether to participate in the exchange.

   The Company's rate filings for exchange products are publicly available at the following links:

- Colorado: https://www.dora.state.co.us/pls/real/external_forms.serff_link# (click on "Click here to Search Health Insurance Filings" and search for Rocky Mountain Hospital & Medical Service, Inc. or HMO Colorado Inc.)

- Connecticut: http://www.catalog.state.ct.us/cid/portalApps/RateFilingCompanyDetails.aspx?sF=201403469&sN=60217&sC=Y&sT=H

- Indiana: http://www.in.gov/idoi/2869.htm (Anthem Insurance Companies, Inc.)

- Kentucky: http://insurance.ky.gov/RateFil/default.aspx (search for Anthem Health Plans of Kentucky)

- Maine: http://www.maine.gov/pfr/insurance/PPACA/HFAI.htm# (click on "Click Here to Search Public Filings" and search for Tracking Number AWLP-129567303)

- Nevada: http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Health_Rate_Review/2015-Rate-Filings.pdf

- New York: https://myportal.dfs.ny.gov/web/prior-approval/empirehc/empire-healthchoice-hmo-inc (Empire Health Choice Assurance, Inc., and Empire HealthChoice HMO, Inc.)

- Ohio: http://insurance.ohio.gov/Company/Pages/RecordsRequest.aspx (click on the link to access the HFAI. Then search for Community Insurance Company)

- Virginia: https://www.scc.virginia.gov/boi/SERFFInquiry/LHAccessPage.aspx (Click on Option #2 and search for HealthKeepers, Inc.)

The Company's rate filings for exchange products in California, Georgia, New Hampshire, and Wisconsin are not yet publicly available.

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